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State of Minnesota

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HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 1853

March 18, 2009
Authored by Atkins and Zellers
The bill was read for the first time and referred to the Committee on Commerce and Labor
April 14, 2009
Committee Recommendation and Adoption of Report:
To Pass as Amended
Read Second Time

1.1 A bill for an act
1.2 relating to commerce; regulating various licenses, forms, coverages, marketing
1.3 practices, and records; classifying certain data; removing certain state regulation
1.4 of telephone solicitations; amending Minnesota Statutes 2008, sections 13.716,
1.5 by adding a subdivision; 45.011, subdivision 1; 45.0135, subdivision 7; 58.02,
1.6 subdivision 17; 59B.01; 60A.08, by adding a subdivision; 60A.198, subdivisions
1.7 1, 3; 60A.201, subdivision 3; 60A.205, subdivision 1; 60A.2085, subdivisions 1,
1.8 3, 7, 8; 60A.23, subdivision 8; 60A.235; 60A.32; 61B.19, subdivision 4; 61B.28,
1.9 subdivisions 4, 8; 62A.011, subdivision 3; 62A.136; 62A.3099, subdivision 18;
1.10 62A.31, subdivision 1, by adding a subdivision; 62A.315; 62A.316; 62L.02,
1.11 subdivision 26; 62M.05, subdivision 3a; 65A.27, subdivision 1; 65B.133,
1.12 subdivision 2; 67A.191, subdivision 2; 72A.20, subdivisions 15, 26; 79A.04,
1.13 subdivision 1, by adding a subdivision; 79A.06, by adding a subdivision; 79A.24,
1.14 subdivision 1, by adding a subdivision; 82.31, subdivision 4; 82B.08, by adding a
1.15 subdivision; 82B.20, subdivision 2; 471.98, subdivision 2; 471.982, subdivision
1.16 3; proposing coding for new law in Minnesota Statutes, chapters 62A; 72A;
1.17 82B; 325E; repealing Minnesota Statutes 2008, sections 60A.201, subdivision 4;
1.18 61B.19, subdivision 6; 70A.07; 79.56, subdivision 4.

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

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

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

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

1.25 Subdivision 1. **Scope.** As used in chapters 45 to 83, 155A, 332, 332A, 345, and 359,
1.26 and sections 123A.21, subdivisions 7 and 23, 123A.25; 325D.30 to 325D.42~~,~~; 326B.802
1.27 to 326B.885~~, and~~; 386.61 to 386.78~~,~~; 471.617; and 471.982, unless the context indicates
1.28 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:

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

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

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

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

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

Sec. 4. Minnesota Statutes 2008, section 58.02, subdivision 17, is amended to read:

Subd. 17. **Person in control.** "Person in control" means any member of senior management, including owners or officers, and other persons who possess, directly or indirectly, the power to direct or cause the direction of the management policies of an applicant or licensee under this chapter, regardless of whether the person has any ownership interest in the applicant or licensee. Control is presumed to exist if a person, directly or indirectly, owns, controls, or holds with power to vote ten percent or more of the voting stock of an applicant or licensee or of a person who owns, controls, or holds with power to vote ten percent or more of the voting stock of an applicant or licensee.

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

59B.01 SCOPE AND PURPOSE.

(a) The purpose of this chapter is to create a legal framework within which service contracts may be sold in this state.

(b) The following are exempt from this chapter:

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

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

3.34 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.201, subdivision 3, is amended to read:

Subd. 3. **Unavailability of other coverage; presumption.** There shall be a rebuttable presumption that the following coverages are unavailable from a licensed insurer:

(a) ~~coverages on a list of unavailable coverages maintained by the commissioner pursuant to subdivision 4;~~

~~(b)~~ coverages where one portion of the risk is acceptable to licensed insurers but another portion of the same risk is not acceptable. The entire coverage may be placed with eligible surplus lines insurers if it can be shown that the eligible surplus lines insurer will accept the entire coverage but not the rejected portion alone; and

~~(c)~~ (b) any coverage that the licensee is unable to procure after diligent search among licensed insurers.

Sec. 10. Minnesota Statutes 2008, section 60A.205, subdivision 1, is amended to read:

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

5.7 Sec. 11. Minnesota Statutes 2008, section 60A.2085, subdivision 1, is amended to read:
5.8 Subdivision 1. **Association created; duties.** There is hereby created a nonprofit
5.9 association to be known as the Surplus Lines Association of Minnesota. The association
5.10 is not a state agency for purposes of chapter 16A, 16B, 16C, or 43A. All surplus lines
5.11 licensees are members of this association. Section 60A.208~~, subdivision 5,~~ does not apply
5.12 to the association created pursuant to the provisions of this section. The association shall
5.13 perform its functions under the plan of operation established under subdivision 3 and must
5.14 exercise its powers through a board of directors established under subdivision 2 as set
5.15 forth in the plan of operation. The association shall be authorized and have the duty to:
5.16 (1) receive, record, and stamp all surplus lines insurance documents that surplus
5.17 lines licensees are required to file with the association;
5.18 (2) prepare and deliver monthly to the commissioners of revenue and commerce a
5.19 report regarding surplus lines business. The report must include a list of all the business
5.20 procured during the preceding month, in the form the commissioners prescribe;
5.21 (3) educate its members regarding the surplus lines law of this state including
5.22 insurance tax responsibilities and the rules and regulations of the commissioners of
5.23 revenue and commerce relative to surplus lines insurance;
5.24 (4) communicate with organizations of agents, brokers, and admitted insurers with
5.25 respect to the proper use of the surplus lines market;
5.26 (5) employ and retain persons necessary to carry out the duties of the association;
5.27 (6) borrow money necessary to effect the purposes of the association and grant a
5.28 security interest or mortgage in its assets, including the stamping fees charged pursuant to
5.29 subdivision 7 in order to secure the repayment of any such borrowed money;
5.30 (7) enter contracts necessary to effect the purposes of the association;
5.31 (8) provide other services to its members that are incidental or related to the
5.32 purposes of the association; ~~and~~
5.33 (9) form and organize itself as a nonprofit corporation under chapter 317A, with the
5.34 powers set forth in section 317A.161 that are not otherwise limited by this section or in
5.35 its articles, bylaws, or plan of operation;

6.1 (10) file such applications and take such other action as necessary to establish and
6.2 maintain the association as tax exempt pursuant to the federal income tax code;
6.3 (11) recommend to the commissioner of commerce revisions to Minnesota law
6.4 relating to the regulation of surplus lines insurance in order to improve the efficiency
6.5 and effectiveness of that regulation; and
6.6 ~~(9)~~ (12) take other actions reasonably required to implement the provisions of this
6.7 section.

6.8 Sec. 12. Minnesota Statutes 2008, section 60A.2085, subdivision 3, is amended to read:
6.9 Subd. 3. **Plan of operation.** (a) The plan of operation shall provide for the
6.10 formation, operation, and governance of the association as a nonprofit corporation
6.11 under chapter 317A. The plan of operation must provide for the election of a board of
6.12 directors by the members of the association. The board of directors shall elect officers as
6.13 provided for in the plan of operation. The plan of operation shall establish the manner of
6.14 voting and may weigh each member's vote to reflect the annual surplus lines insurance
6.15 premium written by the member. Members employed by the same or affiliated employers
6.16 may consolidate their premiums written and delegate an individual officer or partner
6.17 to represent the member in the exercise of association affairs, including service on the
6.18 board of directors.
6.19 (b) The plan of operation shall provide for an independent audit once each year of all
6.20 the books and records of the association and a report of such independent audit shall be
6.21 made to the board of directors, the commissioner of revenue, and the commissioner of
6.22 commerce, with a copy made available to each member to review at the association office.
6.23 (c) The plan of operation and any amendments to the plan of operation shall be
6.24 submitted to the commissioner and shall be effective upon approval in writing by the
6.25 commissioner. The association and all members shall comply with the plan of operation or
6.26 any amendments to it. Failure to comply with the plan of operation or any amendments
6.27 shall constitute a violation for which the commissioner may issue an order requiring
6.28 discontinuance of the violation.
6.29 (d) If the interim board of directors fails to submit a suitable plan of operation
6.30 within 60 days following the creation of the interim board, or if at any time thereafter the
6.31 association fails to submit required amendments to the plan, the commissioner may submit
6.32 to the association a plan of operation or amendments to the plan, which the association
6.33 must follow. The plan of operation or amendments submitted by the commissioner shall
6.34 continue in force until amended by the commissioner or superseded by a plan of operation
6.35 or amendment submitted by the association and approved by the commissioner. A plan

7.1 of operation or an amendment submitted by the commissioner constitutes an order of
7.2 the commissioner.

7.3 Sec. 13. Minnesota Statutes 2008, section 60A.2085, subdivision 7, is amended to read:
7.4 Subd. 7. **Stamping fee.** The services performed by the association shall be
7.5 funded by a stamping fee assessed for each premium-bearing document submitted to
7.6 the association. The stamping fee shall be established by the board of directors of the
7.7 association from time to time. The stamping fee shall be paid by the insured to the surplus
7.8 lines licensee and remitted ~~electronically~~ to the association by the surplus lines licensee in
7.9 the manner established by the association.

7.10 Sec. 14. Minnesota Statutes 2008, section 60A.2085, subdivision 8, is amended to read:
7.11 Subd. 8. **Data classification.** Unless otherwise classified by statute, a temporary
7.12 classification under section 13.06, or federal law, information obtained by the
7.13 commissioner from the association is public, except that any data identifying insureds or
7.14 the Social Security number of a licensee or any information derived therefrom is private
7.15 data on individuals or nonpublic data as defined in section 13.02, subdivisions 9 and 12.

7.16 Sec. 15. Minnesota Statutes 2008, section 60A.23, subdivision 8, is amended to read:
7.17 Subd. 8. **Self-insurance or insurance plan administrators who are vendors**
7.18 **of risk management services.** (1) **Scope.** This subdivision applies to any vendor of
7.19 risk management services and to any entity which administers, for compensation, a
7.20 self-insurance or insurance plan. This subdivision does not apply (a) to an insurance
7.21 company authorized to transact insurance in this state, as defined by section 60A.06,
7.22 subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section
7.23 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section
7.24 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for
7.25 its employees' benefits; (e) to an entity which administers a program of health benefits
7.26 established pursuant to a collective bargaining agreement between an employer, or group
7.27 or association of employers, and a union or unions; or (f) to an entity which administers a
7.28 self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance
7.29 to the plan and if the licensed insurer has appointed the entity administering the plan as
7.30 one of its licensed agents within this state.
7.31 (2) **Definitions.** For purposes of this subdivision the following terms have the
7.32 meanings given them.

8.1 (a) "Administering a self-insurance or insurance plan" means (i) processing,
8.2 reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii)
8.3 otherwise providing necessary administrative services in connection with the operation of
8.4 a self-insurance or insurance plan.

8.5 (b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

8.6 (c) "Entity" means any association, corporation, partnership, sole proprietorship,
8.7 trust, or other business entity engaged in or transacting business in this state.

8.8 (d) "Self-insurance or insurance plan" means a plan for the benefit of employees
8.9 or members of an association providing life, medical or hospital care, accident, sickness
8.10 or disability insurance ~~for the benefit of employees or members of an association~~, or
8.11 pharmacy benefits, or a plan providing liability coverage for any other risk or hazard,
8.12 which is or is not directly insured or provided by a licensed insurer, service plan
8.13 corporation, or health maintenance organization.

8.14 (e) "Vendor of risk management services" means an entity providing for
8.15 compensation actuarial, financial management, accounting, legal or other services for the
8.16 purpose of designing and establishing a self-insurance or insurance plan for an employer.

8.17 (3) **License.** No vendor of risk management services or entity administering a
8.18 self-insurance or insurance plan may transact this business in this state unless it is licensed
8.19 to do so by the commissioner. An applicant for a license shall state in writing the type of
8.20 activities it seeks authorization to engage in and the type of services it seeks authorization
8.21 to provide. The license may be granted only when the commissioner is satisfied that the
8.22 entity possesses the necessary organization, background, expertise, and financial integrity
8.23 to supply the services sought to be offered. The commissioner may issue a license subject
8.24 to restrictions or limitations upon the authorization, including the type of services which
8.25 may be supplied or the activities which may be engaged in. The license fee is $1,500
8.26 for the initial application and $1,500 for each three-year renewal. All licenses are for
8.27 a period of three years.

8.28 (4) **Regulatory restrictions; powers of the commissioner.** To assure that
8.29 self-insurance or insurance plans are financially solvent, are administered in a fair and
8.30 equitable fashion, and are processing claims and paying benefits in a prompt, fair,
8.31 and honest manner, vendors of risk management services and entities administering
8.32 insurance or self-insurance plans are subject to the supervision and examination by the
8.33 commissioner. Vendors of risk management services, entities administering insurance or
8.34 self-insurance plans, and insurance or self-insurance plans established or operated by
8.35 them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu
8.36 of an unlimited guarantee from a parent corporation for a vendor of risk management

9.1 services or an entity administering insurance or self-insurance plans, the commissioner
9.2 may accept a surety bond in a form satisfactory to the commissioner in an amount equal to
9.3 120 percent of the total amount of claims handled by the applicant in the prior year. If at
9.4 any time the total amount of claims handled during a year exceeds the amount upon which
9.5 the bond was calculated, the administrator shall immediately notify the commissioner.
9.6 The commissioner may require that the bond be increased accordingly.

9.7 No contract entered into after July 1, 2001, between a licensed vendor of risk
9.8 management services and a group authorized to self-insure for workers' compensation
9.9 liabilities under section 79A.03, subdivision 6, may take effect until it has been filed
9.10 with the commissioner, and either (1) the commissioner has approved it or (2) 60 days
9.11 have elapsed and the commissioner has not disapproved it as misleading or violative of
9.12 public policy.

9.13 (5) **Rulemaking authority.** To carry out the purposes of this subdivision, the
9.14 commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:

9.15 (a) establish reporting requirements for administrators of insurance or self-insurance
9.16 plans;

9.17 (b) establish standards and guidelines to assure the adequacy of financing, reinsuring,
9.18 and administration of insurance or self-insurance plans;

9.19 (c) establish bonding requirements or other provisions assuring the financial integrity
9.20 of entities administering insurance or self-insurance plans; or

9.21 (d) establish other reasonable requirements to further the purposes of this
9.22 subdivision.

9.23 Sec. 16. Minnesota Statutes 2008, section 60A.235, is amended to read:

9.24 **60A.235 STANDARDS FOR DETERMINING WHETHER CONTRACTS**
9.25 **ARE HEALTH PLAN CONTRACTS OR STOP LOSS CONTRACTS.**

9.26 Subdivision 1. **Findings and purpose.** The purpose of this section is to establish
9.27 a standard for the determination of whether an insurance policy or other evidence or
9.28 coverage should be treated as a policy of accident and sickness insurance or a stop loss
9.29 policy for the purpose of the regulation of the business of insurance. The laws regulating
9.30 the business of insurance in Minnesota impose distinctly different requirements upon
9.31 accident and sickness insurance policies and stop loss policies. In particular, the regulation
9.32 of accident and sickness insurance in Minnesota includes measures designed to reform the
9.33 health insurance market, to minimize or prohibit selective rating or rejection of employee
9.34 groups or individual group members based upon health conditions, and to provide access
9.35 to affordable health insurance coverage regardless of preexisting health conditions. The

health care reform provisions enacted in Minnesota will only be effective if they are applied to all insurers and health carriers who in substance, regardless of purported form, engage in the business of issuing health insurance coverage to employees of an employee group. This section applies to insurance companies and health carriers and the policies or other evidence of coverage that they issue. This section does not apply to employers or the benefit plans they establish for their employees.

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

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

(b) "Direct coverage" means coverage under which an insurance company or health carrier assumes a direct obligation to an individual, under the policy or evidence of coverage, with respect to health care expenses incurred by the individual or a member of the individual's family.

(c) "Expected claims" means the amount of claims that, in the absence of a stop loss policy or other insurance or evidence of coverage, are projected to be incurred ~~under~~ by an employer-sponsored plan covering health care expenses.

(d) "Expected plan claims" means the expected claims less the projected claims in excess of the specific attachment point, adjusted to be consistent with the employer's aggregate contract period.

(e) "Health plan" means a health plan as defined in section 62A.011 and includes group coverage regardless of the size of the group.

(f) "Health carrier" means a health carrier as defined in section 62A.011.

Subd. 3. **Health plan policies issued as stop loss coverage.** (a) An insurance company or health carrier issuing or renewing an insurance policy or other evidence of coverage, that provides coverage to an employer for health care expenses incurred under an employer-sponsored plan provided to the employer's employees, retired employees, or their dependents, shall issue the policy or evidence of coverage as a health plan if the policy or evidence of coverage:

(1) has a specific attachment point for claims incurred per individual that is lower than ~~$10,000~~ $20,000; or

(2) has an aggregate attachment point, for groups of 50 or fewer, that is lower than the ~~sum~~ greater of:

~~(i) 140 percent of the first $50,000 of expected plan claims;~~

~~(ii) 120 percent of the next $450,000 of expected plan claims; and~~

~~(iii) 110 percent of the remaining expected plan claims.~~

11.1 (i) $4,000 times the number of group members;
11.2 (ii) 120 percent of expected claims; or
11.3 (iii) $20,000; or
11.4 (3) has an aggregate attachment point for groups of 51 or more that is lower than
11.5 110 percent of expected claims.
11.6 (b) An insurer shall determine the number of persons in a group, for the purposes
11.7 of this section, on a consistent basis, at least annually. Where the insurance policy or
11.8 evidence of coverage applies to a contract period of more than one year, the dollar
11.9 amounts set forth in paragraph (a), clauses (1) and (2), must be multiplied by the length
11.10 of the contract period expressed in years.
11.11 (c) The commissioner may adjust the constant dollar amounts provided in paragraph
11.12 (a), clauses (1) ~~and~~, (2), and (3), on January 1 of any year, based upon changes in
11.13 the medical component of the Consumer Price Index (CPI). Adjustments must be in
11.14 increments of $100 and must not be made unless at least that amount of adjustment is
11.15 required. The commissioner shall publish any change in these dollar amounts at least
11.16 ~~three~~ six months before their effective date.
11.17 (d) A policy or evidence of coverage issued by an insurance company or health
11.18 carrier that provides direct coverage of health care expenses of an individual including a
11.19 policy or evidence of coverage administered on a group basis is a health plan regardless of
11.20 whether the policy or evidence of coverage is denominated as stop loss coverage.
11.21 Subd. 3a. **Actuarial certification.** An insurer shall file with the commissioner
11.22 annually on or before March 15, an actuarial certification certifying that the insurer is in
11.23 compliance with sections 60A.235 and 60A.236. The certification shall be in a form and
11.24 manner, and shall contain information, specified by the commissioner. A copy of the
11.25 certification shall be retained by the insurer at its principal place of business.
11.26 Subd. 4. **Compliance.** (a) An insurance company or health carrier that is required to
11.27 issue a policy or evidence of coverage as a health plan under this section shall, even if the
11.28 policy or evidence of coverage is denominated as stop loss coverage, comply with all the
11.29 laws of this state that apply to the health plan, including, but not limited to, chapters 62A,
11.30 62C, 62D, 62E, 62L, and 62Q.
11.31 (b) With respect to an employer who had been issued a policy or evidence of
11.32 coverage denominated as stop loss coverage before ~~June 2, 1995~~ the effective date of this
11.33 section, compliance with this section is required as of the first renewal date occurring on
11.34 or after ~~June 2, 1995~~ August 1, 2009, and applies to policies issued or renewed on or
11.35 after that date.

12.1 Sec. 17. Minnesota Statutes 2008, section 60A.32, is amended to read:

12.2 **60A.32 RATE FILING FOR CROP HAIL INSURANCE.**

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

12.7 Subd. 2. **Compliance certifications.** In addition to the proposed rates, an insurer
12.8 shall file with the Department of Commerce on a form prescribed by the commissioner a
12.9 written certification, signed by an officer of the insurer, that the rates comply with section
12.10 70A.04. Rates filed under this procedure are effective upon the date of receipt or on a
12.11 subsequent date requested by the insurer.

12.12 Subd. 3. **Fee.** In order to be effective, the filing must be accompanied by payment of
12.13 the applicable filing fee.

12.14 Sec. 18. Minnesota Statutes 2008, section 61B.19, subdivision 4, is amended to read:

12.15 Subd. 4. **Limitation of benefits.** The benefits for which the association may become
12.16 liable shall in no event exceed the lesser of:

12.17 (1) the contractual obligations for which the insurer is liable or would have been
12.18 liable if it were not an impaired or insolvent insurer; or

12.19 (2) subject to the limitation in clause (5), with respect to any one life, regardless of
12.20 the number of policies or contracts:

12.21 (i) ~~$300,000~~ $500,000 in life insurance death benefits, but not more than ~~$100,000~~
12.22 $130,000 in net cash surrender and net cash withdrawal values for life insurance;

12.23 (ii) ~~$300,000~~ $500,000 in health insurance benefits, including any net cash surrender
12.24 and net cash withdrawal values;

12.25 (iii) ~~$100,000~~ $250,000 in annuity net cash surrender and net cash withdrawal values;

12.26 (iv) ~~$300,000~~ $410,000 in present value of annuity benefits for structured settlement
12.27 annuities or for annuities in regard to which periodic annuity benefits, for a period of not
12.28 less than the annuitant's lifetime or for a period certain of not less than ten years, have
12.29 begun to be paid, on or before the date of impairment or insolvency; or

12.30 (3) subject to the limitations in clauses (5) and (6), with respect to each individual
12.31 resident participating in a retirement plan, except a defined benefit plan, established under
12.32 section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through
12.33 December 31, 1992, covered by an unallocated annuity contract, or the beneficiaries
12.34 of each such individual if deceased, in the aggregate, ~~$100,000~~ $250,000 in net cash
12.35 surrender and net cash withdrawal values;

13.1 (4) where no coverage limit has been specified for a covered policy or benefit, the
13.2 coverage limit shall be ~~$300,000~~ $500,000 in present value;
13.3 (5) in no event shall the association be liable to expend more than ~~$300,000~~
13.4 $500,000 in the aggregate with respect to any one life under clause (2), items (i), (ii), (iii),
13.5 (iv), and clause (4), and any one individual under clause (3);
13.6 (6) in no event shall the association be liable to expend more than ~~$7,500,000~~
13.7 $10,000,000 with respect to all unallocated annuities of a retirement plan, except a defined
13.8 benefit plan, established under section 401, 403(b), or 457 of the Internal Revenue Code
13.9 of 1986, as amended through December 31, 1992. If total claims from a plan exceed
13.10 ~~$7,500,000~~ $10,000,000, the ~~$7,500,000~~ $10,000,000 shall be prorated among the
13.11 claimants;
13.12 (7) for purposes of applying clause (2)(ii) and clause (5), with respect only to
13.13 health insurance benefits, the term "any one life" applies to each individual covered by a
13.14 health insurance policy;
13.15 (8) where covered contractual obligations are equal to or less than the limits stated in
13.16 this subdivision, the association will pay the difference between the covered contractual
13.17 obligations and the amount credited by the estate of the insolvent or impaired insurer, if
13.18 that amount has been determined or, if it has not, the covered contractual limit, subject
13.19 to the association's right of subrogation;
13.20 (9) where covered contractual obligations exceed the limits stated in this subdivision,
13.21 the amount payable by the association will be determined as though the covered
13.22 contractual obligations were equal to those limits. In making the determination, the estate
13.23 shall be deemed to have credited the covered person the same amount as the estate would
13.24 credit a covered person with contractual obligations equal to those limits; or
13.25 (10) the following illustrates how the principles stated in clauses (8) and (9) apply.
13.26 The example illustrated concerns hypothetical claims subject to the limit stated in clause
13.27 (2)(iii). The principles stated in clauses (8) and (9), and illustrated in this clause, apply
13.28 to claims subject to any limits stated in this subdivision.

13.29 CONTRACTUAL OBLIGATIONS OF:

		$50,000	
13.31–13.32		Estate	Guaranty Association
13.33–13.34	0% recovery from estate	$ 0	$ 50,000
13.35–13.36	25% recovery from estate	$ 12,500	$ 37,500
13.37–13.38	50% recovery from estate	$ 25,000	$ 25,000

	Estate	Guaranty Association
75% recovery from estate	$ 37,500	$ 12,500

$100,000

	Estate	Guaranty Association
0% recovery from estate	$ 0	$ 100,000
25% recovery from estate	$ 25,000	$ 75,000
50% recovery from estate	$ 50,000	$ 50,000
75% recovery from estate	$ 75,000	$ 25,000

$200,000

	Estate	Guaranty Association
0% recovery from estate	$ 0	$ 100,000
25% recovery from estate	$ 50,000	$ 75,000
50% recovery from estate	$ 100,000	$ 50,000
75% recovery from estate	$ 150,000	$ 25,000

For purposes of this subdivision, the commissioner shall determine the discount rate to be used in determining the present value of annuity benefits.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to member insurers who are first determined to be impaired or insolvent on or after this effective date. Member insurers who are subject to an order of impairment in effect on the effective date but are not declared insolvent until after the effective date shall continue to be governed by the law in effect prior to the effective date.

Sec. 19. Minnesota Statutes 2008, section 61B.28, subdivision 4, is amended to read:

Subd. 4. **Prohibited sales practice.** No person, including an insurer, agent, or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, an advertisement, announcement, or statement, written or oral, which uses the existence of the Minnesota Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by sections 61B.18 to 61B.32. The notice required by subdivision 8

15.1 is not a violation of this subdivision nor is it a violation of this subdivision to explain
15.2 verbally to an applicant or potential applicant the coverage provided by the Minnesota
15.3 Life and Health Insurance Guaranty Association at any time during the application process
15.4 or thereafter. This subdivision does not apply to the Minnesota Life and Health Insurance
15.5 Guaranty Association or an entity that does not sell or solicit insurance. ~~A person violating~~
15.6 ~~this section is guilty of a misdemeanor.~~

15.7 Sec. 20. Minnesota Statutes 2008, section 61B.28, subdivision 8, is amended to read:
15.8 Subd. 8. **Form.** The form of notice referred to in subdivision 7, paragraph (a),
15.9 is as follows:

15.10 "...................
15.11 ....
15.12 ....
15.13 (insert name, current address, and
15.14 telephone number of insurer)

15.15 NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN
15.16 INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH
15.17 INSURANCE GUARANTY ASSOCIATION LAW

15.18 If the insurer that issued your life, annuity, or health insurance policy becomes
15.19 impaired or insolvent, you are entitled to compensation for your policy from the assets of
15.20 that insurer. The amount you recover will depend on the financial condition of the insurer.
15.21 In addition, residents of Minnesota who purchase life insurance, annuities, or health
15.22 insurance from insurance companies authorized to do business in Minnesota are protected,
15.23 SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially
15.24 impaired or insolvent. This protection is provided by the Minnesota Life and Health
15.25 Insurance Guaranty Association.

15.26 Minnesota Life and Health Insurance Guaranty Association
15.27 (insert current
15.28 address and telephone number)

15.29 The maximum amount the guaranty association will pay for all policies issued on
15.30 one life by the same insurer is limited to ~~$300,000~~ $500,000. Subject to this ~~$300,000~~
15.31 $500,000 limit, the guaranty association will pay up to ~~$300,000~~ $500,000 in life
15.32 insurance death benefits, ~~$100,000~~ $130,000 in net cash surrender and net cash withdrawal
15.33 values for life insurance, ~~$300,000~~ $500,000 in health insurance benefits, including any
15.34 net cash surrender and net cash withdrawal values, ~~$100,000~~ $250,000 in annuity net
15.35 cash surrender and net cash withdrawal values, ~~$300,000~~ $410,000 in present value of
15.36 annuity benefits for annuities which are part of a structured settlement or for annuities
15.37 in regard to which periodic annuity benefits, for a period of not less than the annuitant's

16.1 lifetime or for a period certain of not less than ten years, have begun to be paid on or
16.2 before the date of impairment or insolvency, or if no coverage limit has been specified
16.3 for a covered policy or benefit, the coverage limit shall be ~~$300,000~~ $500,000 in present
16.4 value. Unallocated annuity contracts issued to retirement plans, other than defined benefit
16.5 plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of
16.6 1986, as amended through December 31, 1992, are covered up to ~~$100,000~~ $250,000 in
16.7 net cash surrender and net cash withdrawal values, for Minnesota residents covered by
16.8 the plan provided, however, that the association shall not be responsible for more than
16.9 ~~$7,500,000~~ $10,000,000 in claims from all Minnesota residents covered by the plan. If
16.10 total claims exceed ~~$7,500,000~~ $10,000,000, the ~~$7,500,000~~ $10,000,000 shall be prorated
16.11 among all claimants. These are the maximum claim amounts. Coverage by the guaranty
16.12 association is also subject to other substantial limitations and exclusions and requires
16.13 continued residency in Minnesota. If your claim exceeds the guaranty association's limits,
16.14 you may still recover a part or all of that amount from the proceeds of the liquidation of
16.15 the insolvent insurer, if any exist. Funds to pay claims may not be immediately available.
16.16 The guaranty association assesses insurers licensed to sell life and health insurance in
16.17 Minnesota after the insolvency occurs. Claims are paid from this assessment.

16.18 THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT
16.19 A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES
16.20 THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN
16.21 INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE
16.22 BY THE GUARANTY ASSOCIATION.

16.23 THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE
16.24 POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES
16.25 OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES
16.26 FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE
16.27 COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE,
16.28 ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE
16.29 THIS NOTICE."

16.30 Additional language may be added to the notice if approved by the commissioner
16.31 prior to its use in the form. This section does not apply to fraternal benefit societies
16.32 regulated under chapter 64B.

16.33 **EFFECTIVE DATE.** This section is effective 30 days following final enactment.

16.34 Sec. 21. Minnesota Statutes 2008, section 62A.011, subdivision 3, is amended to read:

17.1 Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and
17.2 sickness insurance as defined in section 62A.01 offered by an insurance company licensed
17.3 under chapter 60A; a subscriber contract or certificate offered by a nonprofit health
17.4 service plan corporation operating under chapter 62C; a health maintenance contract or
17.5 certificate offered by a health maintenance organization operating under chapter 62D; a
17.6 health benefit certificate offered by a fraternal benefit society operating under chapter
17.7 64B; or health coverage offered by a joint self-insurance employee health plan operating
17.8 under chapter 62H. Health plan means individual and group coverage, unless otherwise
17.9 specified. Health plan does not include coverage that is:

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

17.11 (2) automobile medical payment coverage;

17.12 (3) supplemental to liability insurance;

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

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

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

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

17.18 (8) accident-only coverage;

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

17.20 (10) issued as a supplement to Medicare, as defined in sections 62A.3099 to
17.21 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health
17.22 maintenance organizations or those policies, contracts, or certificates governed by section
17.23 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section
17.24 1395, et seq., as amended;

17.25 (11) workers' compensation insurance; or

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

17.29 Sec. 22. Minnesota Statutes 2008, section 62A.136, is amended to read:

17.30 **62A.136 HEARING, DENTAL, AND VISION PLAN COVERAGE.**

17.31 The following provisions do not apply to health plans as defined in section 62A.011,
17.32 subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections
17.33 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17,
17.34 subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304;
17.35 62A.3093; and 62E.16.

18.1 Sec. 23. Minnesota Statutes 2008, section 62A.3099, subdivision 18, is amended to
18.2 read:

18.3 Subd. 18. **Medicare supplement policy or certificate.** "Medicare supplement
18.4 policy or certificate" means a group or individual policy of accident and sickness insurance
18.5 or a subscriber contract of hospital and medical service associations or health maintenance
18.6 organizations, other than those policies or certificates covered by section 1833 of the
18.7 federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued
18.8 policy under a demonstration project specified under amendments to the federal Social
18.9 Security Act, which is advertised, marketed, or designed primarily as a supplement to
18.10 reimbursements under Medicare for the hospital, medical, or surgical expenses of persons
18.11 eligible for Medicare or as a supplement to Medicare Advantage Plans established under
18.12 Medicare Part C. "Medicare supplement policy" does not include Medicare Advantage
18.13 plans established under Medicare Part C, outpatient prescription drug plans established
18.14 under Medicare Part D, or any health care prepayment plan that provides benefits under an
18.15 agreement under section 1833(a)(1)(A) of the Social Security Act.

18.16 Sec. 24. Minnesota Statutes 2008, section 62A.31, subdivision 1, is amended to read:

18.17 Subdivision 1. **Policy requirements.** No individual or group policy, certificate,
18.18 subscriber contract issued by a health service plan corporation regulated under chapter
18.19 62C, or other evidence of accident and health insurance the effect or purpose of which
18.20 is to supplement Medicare coverage, including to supplement coverage under Medicare
18.21 Advantage Plans established under Medicare Part C, issued or delivered in this state
18.22 or offered to a resident of this state shall be sold or issued to an individual covered by
18.23 Medicare unless the requirements in subdivisions 1a to 1u are met.

18.24 Sec. 25. Minnesota Statutes 2008, section 62A.31, is amended by adding a subdivision
18.25 to read:

18.26 Subd. 8. **Prohibition against use of genetic information and requests for genetic**
18.27 **information.** This subdivision applies to all policies with policy years beginning on or
18.28 after May 21, 2009.

18.29 (a) An issuer of a Medicare supplement policy or certificate:

18.30 (1) shall not deny or condition the issuance or effectiveness of the policy or
18.31 certificate, including the imposition of any exclusion of benefits under the policy based
18.32 on a preexisting condition, on the basis of the genetic information with respect to such
18.33 individual; and

19.1 (2) shall not discriminate in the pricing of the policy or certificate, including the
19.2 adjustment of premium rates, of an individual on the basis of the genetic information
19.3 with respect to such individual.
19.4 (b) Nothing in paragraph (a) shall be construed to limit the ability of an issuer, to the
19.5 extent otherwise permitted by law, from:
19.6 (1) denying or conditioning the issuance or effectiveness of the policy or certificate
19.7 or increasing the premium for a group based on the manifestation of a disease or disorder
19.8 of an insured or applicant; or
19.9 (2) increasing the premium for any policy issued to an individual based on the
19.10 manifestation of a disease or disorder of an individual who is covered under the policy.
19.11 In such case, the manifestation of a disease or disorder in one individual cannot also
19.12 be used as genetic information about other group members and to further increase the
19.13 premium for the group.
19.14 (c) An issuer of a Medicare supplement policy or certificate shall not request or
19.15 require an individual or a family member of such individual to undergo a genetic test.
19.16 (d) Paragraph (c) shall not be construed to preclude an issuer of a Medicare
19.17 supplement policy or certificate from obtaining and using the results of a genetic test in
19.18 making a determination regarding payment, as defined for the purposes of applying the
19.19 regulations promulgated under Part C of title XI and section 264 of the Health Insurance
19.20 Portability and Accountability Act of 1996 as they may be revised from time to time,
19.21 and consistent with paragraph (a).
19.22 (e) For purposes of carrying out paragraph (d), an issuer of a Medicare supplement
19.23 policy or certificate may request only the minimum amount of information necessary to
19.24 accomplish the intended purpose.
19.25 (f) Notwithstanding paragraph (c), an issuer of a Medicare supplement policy may
19.26 request, but not require, that an individual or a family member of such individual undergo
19.27 a genetic test if each of the following conditions are met:
19.28 (1) The request is made pursuant to research that complies with Code of Federal
19.29 Regulations title 45, part 46, or equivalent federal regulations, and any applicable state or
19.30 local law or regulations for the protection of human subjects in research.
19.31 (2) The issuer clearly indicates to each individual, or in the case of a minor child, to
19.32 the legal guardian of such child, to whom the request is made that:
19.33 (i) compliance with the request is voluntary; and
19.34 (ii) noncompliance will have no effect on enrollment status or premium or
19.35 contribution amounts.

20.1 (3) No genetic information collected or acquired under this paragraph shall be used
20.2 for underwriting, determination of eligibility to enroll or maintain enrollment status,
20.3 premium rates, or the issuance, renewal, or replacement of a policy or certificate.
20.4 (4) The issuer notifies the secretary in writing that the issuer is conducting activities
20.5 pursuant to the exception provided for under this paragraph, including a description of
20.6 the activities conducted.
20.7 (5) The issuer complies with such other conditions as the secretary may by regulation
20.8 require for activities under this paragraph.
20.9 (g) An issuer of a Medicare supplement policy or certificate shall not request,
20.10 require, or purchase genetic information for underwriting purposes.
20.11 (h) An issuer of a Medicare supplement policy or certificate shall not request,
20.12 require, or purchase genetic information with respect to any individual prior to such
20.13 individual's enrollment under the policy in connection with such enrollment.
20.14 (i) An issuer of a Medicare supplement policy or certificate that obtains genetic
20.15 information incidental to the requesting, requiring, or purchasing of other information
20.16 concerning any individual, such request, requirement, or purchase shall not be considered
20.17 a violation of paragraph (h) if such request, requirement, or purchase is not in violation of
20.18 paragraph (g).
20.19 (j) For purposes of this subdivision only:
20.20 (1) "Family member" means, with respect to an individual, any other individual who
20.21 is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.
20.22 (2) "Genetic information" means, with respect to any individual, information about
20.23 such individual's genetic tests, the genetic test of family members of such individual,
20.24 and the manifestation of a disease or disorder in family members of such individual.
20.25 Such terms includes, with respect to any individual, any request for, or receipt of, genetic
20.26 services, or participation in clinical research that includes genetic services, by such
20.27 individual or any family member of such individual. Any reference to genetic information
20.28 concerning an individual or family member of an individual who is a pregnant woman,
20.29 includes genetic information of any fetus carried by such pregnant woman, or with respect
20.30 to an individual or family member utilizing reproductive technology, includes genetic
20.31 information of any embryo legally held by an individual or family member. The term
20.32 genetic information does not include information about the sex or age of any individual.
20.33 (3) "Genetic services" means a genetic test or genetic counseling, including
20.34 obtaining, interpreting, or assessing genetic information or genetic education.
20.35 (4) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins,
20.36 or metabolites, that detect genotypes, mutations, or chromosomal changes. The term

21.1 genetic test does not mean an analysis of proteins or metabolites that does not detect
21.2 genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites
21.3 that is directly related to a manifested disease, disorder, or pathological condition that
21.4 could reasonably be detected by a health care professional with appropriate training and
21.5 expertise in the field of medicine involved.

21.6 (5) "Issuer of a Medicare supplement policy or certificate" includes a third-party
21.7 administrator or other person acting for or on behalf of such issuer.

21.8 (6) "Underwriting purposes" means:

21.9 (i) rules for, or determination of, eligibility including enrollment and continued
21.10 eligibility, for benefits under the policy;

21.11 (ii) the computation of premium or contribution amounts under the policy;

21.12 (iii) the application of any preexisting condition exclusion under the policy; and

21.13 (iv) other activities related to the creation, renewal, or replacement of a contract of
21.14 health insurance or health benefits.

21.15 Sec. 26. Minnesota Statutes 2008, section 62A.315, is amended to read:

21.16 **62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN;**
21.17 **COVERAGE.**

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

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

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

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

21.29 (4) 80 percent of the usual and customary hospital and medical expenses and
21.30 supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation
21.31 established by the Medicare program or state law, the usual and customary hospital
21.32 and medical expenses and supplies, described in section 62E.06, subdivision 1, while
21.33 in a foreign country; and prescription drug expenses, not covered by Medicare. An
21.34 outpatient prescription drug benefit must not be included for sale or issuance in a Medicare
21.35 supplement policy or certificate issued on or after January 1, 2006;

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

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

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

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

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

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

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

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

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

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

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

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

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

23.1 ~~(A) at-home recovery services provided must be primarily services that assist in~~
23.2 ~~activities of daily living;~~
23.3 ~~(B) the insured's attending physician must certify that the specific type and frequency~~
23.4 ~~of at-home recovery services are necessary because of a condition for which a home care~~
23.5 ~~plan of treatment was approved by Medicare;~~
23.6 ~~(C) coverage is limited to:~~
23.7 ~~(I) no more than the number and type of at-home recovery visits certified as~~
23.8 ~~medically necessary by the insured's attending physician. The total number of at-home~~
23.9 ~~recovery visits shall not exceed the number of Medicare-approved home health care visits~~
23.10 ~~under a Medicare-approved home care plan of treatment;~~
23.11 ~~(II) the actual charges for each visit up to a maximum reimbursement of $100 per~~
23.12 ~~visit;~~
23.13 ~~(III) $4,000 per calendar year;~~
23.14 ~~(IV) seven visits in any one week;~~
23.15 ~~(V) care furnished on a visiting basis in the insured's home;~~
23.16 ~~(VI) services provided by a care provider as defined in this section;~~
23.17 ~~(VII) at-home recovery visits while the insured is covered under the policy or~~
23.18 ~~certificate and not otherwise excluded;~~
23.19 ~~(VIII) at-home recovery visits received during the period the insured is receiving~~
23.20 ~~Medicare-approved home care services or no more than eight weeks after the service date~~
23.21 ~~of the last Medicare-approved home health care visit;~~
23.22 ~~(iii) coverage is excluded for:~~
23.23 ~~(A) home care visits paid for by Medicare or other government programs; and~~
23.24 ~~(B) care provided by unpaid volunteers or providers who are not care providers.~~
23.25 (8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite
23.26 care expenses; and
23.27 (9) coverage for cost sharing for Medicare Part A or B home health care services
23.28 and medical supplies.

23.29 Sec. 27. Minnesota Statutes 2008, section 62A.316, is amended to read:

23.30 **62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

23.31 (a) The basic Medicare supplement plan must have a level of coverage that will
23.32 provide:
23.33 (1) coverage for all of the Medicare Part A inpatient hospital coinsurance amounts,
23.34 and 100 percent of all Medicare part A eligible expenses for hospitalization not covered
23.35 by Medicare, after satisfying the Medicare Part A deductible;

24.1 (2) coverage for the daily co-payment amount of Medicare Part A eligible expenses
24.2 for the calendar year incurred for skilled nursing facility care;
24.3 (3) coverage for the coinsurance amount, or in the case of outpatient department
24.4 services paid under a prospective payment system, the co-payment amount, of Medicare
24.5 eligible expenses under Medicare Part B regardless of hospital confinement, subject to
24.6 the Medicare Part B deductible amount;
24.7 (4) 80 percent of the hospital and medical expenses and supplies incurred during
24.8 travel outside the United States as a result of a medical emergency;
24.9 (5) coverage for the reasonable cost of the first three pints of blood, or equivalent
24.10 quantities of packed red blood cells as defined under federal regulations under Medicare
24.11 Parts A and B, unless replaced in accordance with federal regulations;
24.12 (6) 100 percent of the cost of immunizations not otherwise covered under Part D of
24.13 the Medicare program and routine screening procedures for cancer screening including
24.14 mammograms and pap smears; ~~and~~
24.15 (7) 80 percent of coverage for all physician prescribed medically appropriate and
24.16 necessary equipment and supplies used in the management and treatment of diabetes
24.17 not otherwise covered under Part D of the Medicare program. Coverage must include
24.18 persons with gestational, type I, or type II diabetes. Coverage under this clause is subject
24.19 to section 62A.3093, subdivision 2~~.~~;
24.20 (8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite
24.21 care expenses; and
24.22 (9) coverage for cost sharing for Medicare Part A or B home health care services and
24.23 medical supplies subject to the Medicare Part B deductible amount.
24.24 (b) ~~Only~~ The following ~~optional~~ benefit riders ~~may be added to~~ must be offered
24.25 with this plan:
24.26 (1) coverage for all of the Medicare Part A inpatient hospital deductible amount;
24.27 (2) ~~a minimum of 80 percent of eligible medical expenses and supplies not covered~~
24.28 ~~by Medicare Part B~~ 100 percent of the Medicare Part B excess charges coverage for
24.29 all of the difference between the actual Medicare Part B charges as billed, not to
24.30 exceed any charge limitation established by the Medicare program or state law, and the
24.31 Medicare-approved Part B charge;
24.32 (3) coverage for all of the Medicare Part B annual deductible; and
24.33 ~~(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and~~
24.34 ~~customary prescription drug expenses. An outpatient prescription drug benefit must not~~
24.35 ~~be included for sale or issuance in a Medicare policy or certificate issued on or after~~
24.36 ~~January 1, 2006;~~

~~(5)~~ (4) preventive medical care benefit coverage for the following preventative health services not covered by Medicare:

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

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

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

~~(6) coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:~~

~~(i) For purposes of this benefit, the following definitions apply:~~

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

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

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

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

~~(ii) Coverage requirements and limitations:~~

~~(A) at-home recovery services provided must be primarily services that assist in 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:~~

26.1 ~~(I) no more than the number and type of at-home recovery visits certified as~~
26.2 ~~necessary by the insured's attending physician. The total number of at-home recovery~~
26.3 ~~visits shall not exceed the number of Medicare-approved home care visits under a~~
26.4 ~~Medicare-approved home care plan of treatment;~~
26.5 ~~(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;~~
26.6 ~~(III) $1,600 per calendar year;~~
26.7 ~~(IV) seven visits in any one week;~~
26.8 ~~(V) care furnished on a visiting basis in the insured's home;~~
26.9 ~~(VI) services provided by a care provider as defined in this section;~~
26.10 ~~(VII) at-home recovery visits while the insured is covered under the policy or~~
26.11 ~~certificate and not otherwise excluded;~~
26.12 ~~(VIII) at-home recovery visits received during the period the insured is receiving~~
26.13 ~~Medicare-approved home care services or no more than eight weeks after the service date~~
26.14 ~~of the last Medicare-approved home health care visit;~~
26.15 ~~(iii) Coverage is excluded for:~~
26.16 ~~(A) home care visits paid for by Medicare or other government programs; and~~
26.17 ~~(B) care provided by family members, unpaid volunteers, or providers who are~~
26.18 ~~not care providers;~~
26.19 ~~(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and~~
26.20 ~~customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually~~
26.21 ~~under this benefit. An issuer of Medicare supplement insurance policies that elects to~~
26.22 ~~offer this benefit rider shall also make available coverage that contains the rider specified~~
26.23 ~~in clause (4). An outpatient prescription drug benefit must not be included for sale or~~
26.24 ~~issuance in a Medicare policy or certificate issued on or after January 1, 2006.~~

26.25 Sec. 28. <u>**[62A.3163] MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT**</u>
26.26 <u>**PART A DEDUCTIBLE COVERAGE.**</u>
26.27 <u>The Medicare supplement plan with 50 percent Part A deductible coverage must</u>
26.28 <u>have a level of coverage that will provide:</u>
26.29 <u>(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for</u>
26.30 <u>365 days after Medicare benefits end;</u>
26.31 <u>(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible</u>
26.32 <u>amount per benefit period;</u>
26.33 <u>(3) coverage for the coinsurance amount for each day used from the 21st through</u>
26.34 <u>the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible</u>
26.35 <u>under Medicare Part A;</u>

27.1 (4) coverage for cost sharing for all Medicare Part A eligible hospice and respite
27.2 care expenses;
27.3 (5) coverage under Medicare Part A or B for the reasonable cost of the first three
27.4 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal
27.5 regulations;
27.6 (6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare
27.7 Part B, after the policyholder pays the Medicare Part B deductible;
27.8 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
27.9 services and diagnostic procedures for cancer screening described in section 62A.30 after
27.10 the policyholder pays the Medicare Part B deductible;
27.11 (8) coverage of 80 percent of the hospital and medical expenses and supplies
27.12 incurred during travel outside of the United States as a result of a medical emergency; and
27.13 (9) coverage for 100 percent of the Medicare Part A or B home health care services
27.14 and medical supplies after the policyholder pays the Medicare Part B deductible.

27.15 Sec. 29. **[62A.3164] MEDICARE SUPPLEMENT PLAN WITH $20 AND $50**
27.16 **CO-PAYMENT MEDICARE PART B COVERAGE.**
27.17 The Medicare supplement plan with $20 and $50 co-payment Medicare Part B
27.18 coverage must have a level of coverage that will provide:
27.19 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
27.20 365 days after Medicare benefits end;
27.21 (2) coverage for the Medicare Part A inpatient hospital deductible amount per
27.22 benefit period;
27.23 (3) coverage for the coinsurance amount for each day used from the 21st through
27.24 the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible
27.25 under Medicare Part A;
27.26 (4) coverage for the cost sharing for all Medicare Part A eligible hospice and respite
27.27 care expenses;
27.28 (5) coverage for Medicare Part A or B of the reasonable cost of the first three pints
27.29 of blood, or equivalent quantities of packed red blood cells, as defined under federal
27.30 regulations, unless replaced according to federal regulations;
27.31 (6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare
27.32 Part B except for the lesser of $20 or the Medicare Part B coinsurance or co-payment
27.33 for each covered health care provider office visit and the lesser of $50 or the Medicare
27.34 Part B coinsurance or co-payment for each covered emergency room visit; however, this

28.1 co-payment shall be waived if the insured is admitted to any hospital and the emergency
28.2 visit is subsequently covered as a Medicare Part A expense;
28.3 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
28.4 services and diagnostic procedures for cancer screening described in section 62A.30 after
28.5 the policyholder pays the Medicare Part B deductible;
28.6 (8) coverage of 80 percent of the hospital and medical expenses and supplies
28.7 incurred during travel outside of the United States as a result of a medical emergency; and
28.8 (9) coverage for Medicare Part A or B home health care services and medical
28.9 supplies after the policyholder pays the Medicare Part B deductible.

28.10 Sec. 30. **[62A.3165] MEDICARE SUPPLEMENT PLAN WITH HIGH**
28.11 **DEDUCTIBLE COVERAGE.**
28.12 The Medicare supplement plan will pay 100 percent coverage upon payment of the
28.13 annual high deductible. The annual deductible shall consist of out-of-pocket expenses,
28.14 other than premiums, for services covered. This plan must have a level of coverage that
28.15 will provide:
28.16 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
28.17 365 days after Medicare benefits end;
28.18 (2) coverage for 100 percent of the Medicare Part A inpatient hospital deductible
28.19 amount per benefit period;
28.20 (3) coverage for 100 percent of the coinsurance amount for each day used from the
28.21 21st through the 100th day in a Medicare benefit period for post-hospital skilled nursing
28.22 care eligible under Medicare Part A;
28.23 (4) coverage for 100 percent of cost sharing for all Medicare Part A eligible
28.24 expenses and respite care;
28.25 (5) coverage for 100 percent, under Medicare Part A or B, of the reasonable cost of
28.26 the first three pints of blood, or equivalent quantities of packed red blood cells, as defined
28.27 under federal regulations, unless replaced according to federal regulations;
28.28 (6) except for coverage provided in this clause, coverage for 100 percent of the cost
28.29 sharing otherwise applicable under Medicare Part B;
28.30 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
28.31 services and diagnostic procedures for cancer screening described in section 62A.30 after
28.32 the policyholder pays the Medicare Part B deductible;
28.33 (8) coverage of 100 percent of the hospital and medical expenses and supplies
28.34 incurred during travel outside of the United States as a result of a medical emergency;

29.1 (9) coverage for 100 percent of Medicare Part A and B home health care services
29.2 and medical supplies; and
29.3 (10) the basis for the deductible shall be $1,860 and shall be adjusted annually from
29.4 2010 by the secretary of the United States Department of Health and Human Services to
29.5 reflect the change in the Consumer Price Index for all urban consumers for the 12-month
29.6 period ending with August of the preceding year, and rounded to the nearest multiple of
29.7 $10.

29.8 Sec. 31. Minnesota Statutes 2008, section 62L.02, subdivision 26, is amended to read:
29.9 Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar
29.10 year and a plan year, a person, firm, corporation, partnership, association, or other entity
29.11 actively engaged in business in Minnesota, including a political subdivision of the state,
29.12 that employed an average of no fewer than two nor more than 50 current employees on
29.13 business days during the preceding calendar year and that employs at least two current
29.14 employees on the first day of the plan year. If an employer has only one eligible employee
29.15 who has not waived coverage, the sale of a health plan to or for that eligible employee
29.16 is not a sale to a small employer and is not subject to this chapter and may be treated as
29.17 the sale of an individual health plan. A small employer plan may be offered through a
29.18 domiciled association to self-employed individuals and small employers who are members
29.19 of the association, even if the self-employed individual or small employer has fewer than
29.20 two current employees. Entities that are treated as a single employer under subsection (b),
29.21 (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single
29.22 employer for purposes of determining the number of current employees. Small employer
29.23 status must be determined on an annual basis as of the renewal date of the health benefit
29.24 plan. The provisions of this chapter continue to apply to an employer who no longer meets
29.25 the requirements of this definition until the annual renewal date of the employer's health
29.26 benefit plan. If an employer was not in existence throughout the preceding calendar year,
29.27 the determination of whether the employer is a small employer is based upon the average
29.28 number of current employees that it is reasonably expected that the employer will employ
29.29 on business days in the current calendar year. For purposes of this definition, the term
29.30 employer includes any predecessor of the employer. An employer that has more than 50
29.31 current employees but has 50 or fewer employees, as "employee" is defined under United
29.32 States Code, title 29, section 1002(6), is a small employer under this subdivision.
29.33 (b) Where an association, as defined in section 62L.045, comprised of employers
29.34 contracts with a health carrier to provide coverage to its members who are small employers,
29.35 the association and health benefit plans it provides to small employers, are subject to

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

30.12 Sec. 32. Minnesota Statutes 2008, section 62M.05, subdivision 3a, is amended to read:
30.13 Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an
30.14 initial determination on all requests for utilization review must be communicated to the
30.15 provider and enrollee in accordance with this subdivision within ten business days of the
30.16 request, provided that all information reasonably necessary to make a determination on the
30.17 request has been made available to the utilization review organization.
30.18 (b) When an initial determination is made to certify, notification must be provided
30.19 promptly by telephone to the provider. The utilization review organization shall send
30.20 written notification to the provider or shall maintain an audit trail of the determination
30.21 and telephone notification. For purposes of this subdivision, "audit trail" includes
30.22 documentation of the telephone notification, including the date; the name of the person
30.23 spoken to; the enrollee; the service, procedure, or admission certified; and the date of
30.24 the service, procedure, or admission. If the utilization review organization indicates
30.25 certification by use of a number, the number must be called the "certification number."
30.26 For purposes of this subdivision, notification may also be made by facsimile to a verified
30.27 number or by electronic mail to a secure electronic mailbox. These electronic forms of
30.28 notification satisfy the "audit trail" requirement of this paragraph.
30.29 (c) When an initial determination is made not to certify, notification must be
30.30 provided by telephone, by facsimile to a verified number, or by electronic mail to a
30.31 secure electronic mailbox within one working day after making the determination to
30.32 the attending health care professional and hospital ~~and a written~~ as applicable. Written
30.33 notification must also be sent to the hospital~~,~~ as applicable and attending health care
30.34 professional~~, and enrollee~~ if notification occurred by telephone. For purposes of this
30.35 subdivision, notification may be made by facsimile to a verified number or by electronic

31.1 mail to a secure electronic mailbox. Written notification must be sent to the enrollee and
31.2 may be sent by United States mail, facsimile to a verified number, or by electronic mail to
31.3 a secure mailbox. The written notification must include the principal reason or reasons
31.4 for the determination and the process for initiating an appeal of the determination. Upon
31.5 request, the utilization review organization shall provide the provider or enrollee with the
31.6 criteria used to determine the necessity, appropriateness, and efficacy of the health care
31.7 service and identify the database, professional treatment parameter, or other basis for the
31.8 criteria. Reasons for a determination not to certify may include, among other things,
31.9 the lack of adequate information to certify after a reasonable attempt has been made to
31.10 contact the provider or enrollee.

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

31.15 Sec. 33. Minnesota Statutes 2008, section 65A.27, subdivision 1, is amended to read:

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

31.18 Sec. 34. Minnesota Statutes 2008, section 65B.133, subdivision 2, is amended to read:

31.19 Subd. 2. **Disclosure to applicants.** Before accepting the initial premium payment,
31.20 an insurer or its agent shall provide a surcharge disclosure statement to any person who
31.21 applies for a policy which is effective on or after January 1, 1983. If the insurer provides
31.22 the surcharge disclosure statement on the insurer's website, the insurer may notify the
31.23 applicant orally or in writing of its availability for review on its website prior to accepting
31.24 the initial payment in lieu of providing a disclosure statement to the applicant in writing if
31.25 the insurer so notifies the applicant of the availability of a written version of this statement
31.26 upon the applicant's request. The insurer shall provide the surcharge disclosure statement
31.27 in writing if requested by the applicant.

31.28 Sec. 35. Minnesota Statutes 2008, section 67A.191, subdivision 2, is amended to read:

31.29 Subd. 2. **Homeowner's risks.** A township mutual fire insurance company may issue
31.30 policies known as "homeowner's insurance" as defined in section 65A.27, subdivision
31.31 4, only in combination with a policy issued by an insurer authorized to sell property
31.32 and casualty insurance in this state. All portions of the combination policy providing

32.1 homeowner's insurance, including those issued by a township mutual insurance company,
32.2 ~~shall be~~ are subject to the provisions of chapter 65A and sections 72A.20 and 72A.201.

32.3 Sec. 36. Minnesota Statutes 2008, section 72A.20, subdivision 15, is amended to read:
32.4 Subd. 15. **Practices not held to be discrimination or rebates.** Nothing in
32.5 subdivision 8, 9, or 10, or in section 72A.12, subdivisions 3 and 4, shall be construed as
32.6 including within the definition of discrimination or rebates any of the following practices:
32.7 (1) in the case of any contract of life insurance or annuity, paying bonuses to
32.8 policyholders or otherwise abating their premiums in whole or in part out of surplus
32.9 accumulated from nonparticipating insurance, provided that any bonuses or abatement
32.10 of premiums shall be fair and equitable to policyholders and for the best interests of the
32.11 company and its policyholders;
32.12 (2) in the case of life insurance policies issued on the industrial debit plan, making
32.13 allowance, to policyholders who have continuously for a specified period made premium
32.14 payments directly to an office of the insurer, in an amount which fairly represents the
32.15 saving in collection expense;
32.16 (3) readjustment of the rate of premium for a group insurance policy based on the
32.17 loss or expense experienced thereunder, at the end of the first or any subsequent policy
32.18 year of insurance thereunder, which may be made retroactive only for such policy year;
32.19 (4) in the case of an individual or group health insurance policy, the payment of
32.20 differing amounts of reimbursement to insureds who elect to receive health care goods
32.21 or services from providers designated by the insurer~~, provided that each insurer shall on~~
32.22 ~~or before August 1 of each year file with the commissioner summary data regarding the~~
32.23 ~~financial reimbursement offered to providers so designated.~~; and
32.24 ~~Any insurer which proposes to offer an arrangement authorized under this clause~~
32.25 ~~shall disclose prior to its initial offering and on or before August 1 of each year thereafter~~
32.26 ~~as a supplement to its annual statement submitted to the commissioner pursuant to section~~
32.27 ~~60A.13, subdivision 1, the following information:~~
32.28 ~~(a) the name which the arrangement intends to use and its business address;~~
32.29 ~~(b) the name, address, and nature of any separate organization which administers the~~
32.30 ~~arrangement on the behalf of the insurers; and~~
32.31 ~~(c) the names and addresses of all providers designated by the insurer under this~~
32.32 ~~clause and the terms of the agreements with designated health care providers.~~
32.33 ~~The commissioner shall maintain a record of arrangements proposed under this~~
32.34 ~~clause, including a record of any complaints submitted relative to the arrangements.~~

33.1 (5) in the case of an individual or group health insurance policy, offering incentives
33.2 to individuals for taking part in preventive health care services, medical management
33.3 incentive programs, or activities designed to improve the health of the individual.
33.4 If the commissioner requests copies of contracts with a provider under ~~this~~ clause (4)
33.5 and the provider requests a determination, all information contained in the contracts that
33.6 the commissioner determines may place the provider or health care plan at a competitive
33.7 disadvantage is nonpublic data.

33.8 Sec. 37. Minnesota Statutes 2008, section 72A.20, subdivision 26, is amended to read:
33.9 Subd. 26. **Loss experience.** An insurer shall without cost to the insured provide an
33.10 insured with the loss or claims experience of that insured for the current policy period and
33.11 for the two policy periods preceding the current one for which the insurer has provided
33.12 coverage, within 30 days of a request for the information by the policyholder. Whenever
33.13 reporting loss experience data, actual claims paid on behalf of the insured must be reported
33.14 separately from claims incurred but not paid, pooling charges for catastrophic claim
33.15 protection, and any other administrative fees or charges that may be charged as an incurred
33.16 claim expense. Claims experience data must be provided to the insured in accordance with
33.17 state and federal requirements regarding the confidentiality of medical data. The insurer
33.18 shall not be responsible for providing information without cost more often than once in
33.19 a 12-month period. The insurer is not required to provide the information if the policy
33.20 covers the employee of more than one employer and the information is not maintained
33.21 separately for each employer and not all employers request the data.
33.22 An insurer, health maintenance organization, or a third-party administrator may not
33.23 request more than three years of loss or claims experience as a condition of submitting an
33.24 application or providing coverage.
33.25 This subdivision only applies to group life policies and group health policies.

33.26 **EFFECTIVE DATE.** This section is effective for policy renewal proposals
33.27 delivered on or after August 1, 2010.

33.28 Sec. 38. **[72A.204] PROHIBITED USES OF SENIOR-SPECIFIC**
33.29 **CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS.**
33.30 Subdivision 1. **Purpose and scope.** The purpose of this section is to set forth
33.31 standards to protect consumers from misleading and fraudulent marketing practices with
33.32 respect to the use of senior-specific certifications and professional designations in:
33.33 (1) the solicitation, sale, or purchase of a life insurance or annuity product; or

34.1 (2) the provision of advice in connection with the solicitation, sale, or purchase of a
34.2 life insurance or annuity product.
34.3 Subd. 2. **Insurance producer.** For purposes of this section, "insurance producer"
34.4 means a person required to be licensed under the laws of this state to sell, solicit, or
34.5 negotiate insurance, including annuities.
34.6 Subd. 3. **Prohibited uses of senior-specific certifications and professional**
34.7 **designations.** (a) It is an unfair and deceptive act or practice in the business of insurance
34.8 for an insurance producer to use a senior-specific certification or professional designation
34.9 that indicates or implies in such a way as to mislead a client or prospective client that the
34.10 insurance producer has special certification or training in advising or servicing seniors in
34.11 connection with the solicitation, sale, or purchase of a life insurance or annuity product or
34.12 in the provision of advice as to the value of or the advisability of purchasing or selling a
34.13 life insurance or annuity product, either directly or indirectly, including the provision of
34.14 advice through publications or writings or by issuing or promulgating analyses or reports
34.15 related to a life insurance or annuity product.
34.16 (b) The prohibited use of senior-specific certifications or professional designations
34.17 includes, but is not limited to, the following:
34.18 (1) use of a certification or professional designation by an insurance producer who
34.19 has not actually earned or is otherwise ineligible to use such certification or designation;
34.20 (2) use of a nonexistent or self-conferred certification or professional designation;
34.21 (3) use of a certification or professional designation that indicates or implies a level
34.22 of occupational qualifications obtained through education, training, or experience that the
34.23 insurance producer using the certification or designation does not have; and
34.24 (4) use of a certification or professional designation that was obtained from a
34.25 certifying or designating organization that:
34.26 (i) is primarily engaged in the business of instruction in sales or marketing;
34.27 (ii) does not have reasonable standards or procedures for ensuring the competency of
34.28 its certificants or designees;
34.29 (iii) does not have reasonable standards or procedures for monitoring and
34.30 disciplining its certificants or designees for improper or unethical conduct; or
34.31 (iv) does not have reasonable continuing education requirements for its certificants
34.32 or designees in order to maintain the certificate or designation.
34.33 (c) There is a rebuttable presumption that a certifying or designating organization is
34.34 not disqualified solely for the purposes of paragraph (b), clause (4), when the certification
34.35 or designation issued from the organization does not primarily apply to sales or marketing

35.1 and when the organization or the certification or designation in question has been
35.2 accredited by:
35.3 (1) the American National Standards Institute (ANSI);
35.4 (2) the National Commission for Certifying Agencies; or
35.5 (3) any organization that is on the United States Department of Education list
35.6 entitled "Accrediting Agencies Recognized for Title IV Purposes."
35.7 (d) In determining whether a combination of words or an acronym standing for a
35.8 combination of words constitutes a certification or professional designation indicating or
35.9 implying that a person has special certification or training in advising or servicing seniors,
35.10 factors to be considered must include:
35.11 (1) use of one or more words such as "senior," "retirement," "elder," or like words
35.12 combined with one or more words such as "certified," "registered," "chartered," "adviser,"
35.13 "specialist," "consultant," "planner," or like words, in the name of the certification or
35.14 professional designation; and
35.15 (2) the manner in which those words are combined.
35.16 (e) For purposes of this section, a job title within an organization that is licensed or
35.17 registered by a state or federal financial services regulatory agency is not a certification or
35.18 professional designation, unless it is used in a manner that would confuse or mislead a
35.19 reasonable consumer, when the job title:
35.20 (1) indicates seniority or standing within the organization; or
35.21 (2) specifies an individual's area of specialization within the organization.
35.22 (f) For purposes of paragraph (e), "financial services regulatory agency" includes,
35.23 but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers,
35.24 investment advisers, or investment companies as defined under the Investment Company
35.25 Act of 1940.

35.26 Sec. 39. Minnesota Statutes 2008, section 79A.04, subdivision 1, is amended to read:
35.27 Subdivision 1. **Annual securing of liability.** Each year every private self-insuring
35.28 employer shall secure incurred liabilities for the payment of compensation and the
35.29 performance of its obligations and the obligations of all self-insuring employers imposed
35.30 under chapter 176 by renewing the prior year's security deposit or by making a new
35.31 deposit of security. If a new deposit is made, it must be posted ~~within 60 days of the filing~~
35.32 ~~of the self-insured employer's annual report with the commissioner, but in no event later~~
35.33 ~~than July 1~~ in the following manner: within 60 days of the filing of the annual report, the
35.34 security posting for all prior years plus one-third of the posting for the current year; by

36.1 July 31, one-third of the posting for the current year; by October 31, the final one-third of
36.2 the posting for the current year.

36.3 Sec. 40. Minnesota Statutes 2008, section 79A.04, is amended by adding a subdivision
36.4 to read:

36.5 Subd. 2a. **Exceptions.** Notwithstanding the requirements of subdivisions 1
36.6 and 2, the commissioner may, until the next annual securing of liability, adjust this
36.7 required security deposit for the portion attributable to the current year only, if, in the
36.8 commissioner's judgment, the self-insurer will be able to meet its obligations under this
36.9 chapter until the next annual securing of liability.

36.10 Sec. 41. Minnesota Statutes 2008, section 79A.06, is amended by adding a subdivision
36.11 to read:

36.12 Subd. 7. **Insolvency of a self-insurance group insurer.** In the event of the
36.13 insolvency of the insurer of a self-insurance group issued a policy under section 79A.06,
36.14 subdivision 5, including a policy covering only a portion of the period of self-insurance,
36.15 eligibility for chapter 60C coverage under the policy shall be determined by applying the
36.16 requirements of section 60C.09, subdivision 2, clause (3), to each self-insurance group
36.17 member, rather than to the net worth of the self-insurance group entity or the aggregate net
36.18 worth of all members of the self-insurance group entity.

36.19 Sec. 42. Minnesota Statutes 2008, section 79A.24, subdivision 1, is amended to read:

36.20 Subdivision 1. **Annual securing of liability.** Each year every commercial
36.21 self-insurance group shall secure its estimated future liability for the payment of
36.22 compensation and the performance of the obligations of its membership imposed under
36.23 chapter 176. A new deposit must be posted ~~within 30 days of the filing of the commercial~~
36.24 ~~self-insurance group's annual actuarial report with the commissioner~~ in the following
36.25 manner: within 30 days of the filing of the annual report, the security posting for all prior
36.26 years plus one-third of the posting for the current year; by July 31, one-third of the posting
36.27 for the current year; by October 31, the final one-third of the posting for the current year.

36.28 Sec. 43. Minnesota Statutes 2008, section 79A.24, is amended by adding a subdivision
36.29 to read:

36.30 Subd. 2a. **Exceptions.** Notwithstanding the requirements of subdivisions 1
36.31 and 2, the commissioner may, until the next annual securing of liability, adjust this
36.32 required security deposit for the portion attributable to the current year only, if, in the

37.1 commissioner's judgment, the self-insurer will be able to meet its obligations under this
37.2 chapter until the next annual securing of liability.

37.3 Sec. 44. Minnesota Statutes 2008, section 82.31, subdivision 4, is amended to read:

37.4 Subd. 4. **Corporate and partnership licenses.** (a) A corporation applying for
37.5 a license shall have at least one officer individually licensed to act as broker for the
37.6 corporation. The corporation broker's license shall extend no authority to act as broker
37.7 to any person other than the corporate entity. Each officer who intends to act as a broker
37.8 shall obtain a license.

37.9 (b) A partnership applying for a license shall have at least one partner individually
37.10 licensed to act as broker for the partnership. Each partner who intends to act as a broker
37.11 shall obtain a license.

37.12 (c) Applications for a license made by a corporation shall be verified by the president
37.13 and one other officer. Applications made by a partnership shall be verified by at least
37.14 two partners.

37.15 (d) Any partner or officer who ceases to act as broker for a partnership or corporation
37.16 shall notify the commissioner upon said termination. The individual licenses of all
37.17 salespersons acting on behalf of a corporation or partnership, are automatically ineffective
37.18 upon the revocation or suspension of the license of the partnership or corporation.
37.19 The commissioner may suspend or revoke the license of an officer or partner without
37.20 suspending or revoking the license of the corporation or partnership.

37.21 (e) The application of all officers of a corporation or partners in a partnership who
37.22 intend to act as a broker on behalf of a corporation or partnership shall accompany the
37.23 initial license application of the corporation or partnership. Officers or partners intending
37.24 to act as brokers subsequent to the licensing of the corporation or partnership shall procure
37.25 an individual real estate broker's license prior to acting in the capacity of a broker. No
37.26 corporate officer, or partner, who maintains a salesperson's license may exercise any
37.27 authority over any trust account administered by the broker nor may they be vested with
37.28 any supervisory authority over the broker.

37.29 (f) The corporation or partnership applicant shall make available upon request, such
37.30 records and data required by the commissioner for enforcement of this chapter.

37.31 (g) The commissioner may require further information, as the commissioner deems
37.32 appropriate, to administer the provisions and further the purposes of this chapter.

37.33 Sec. 45. **[82B.071] RECORDS.**

38.1 Subdivision 1. **Examination of records.** The commissioner may make examinations
38.2 within or without this state of each real estate appraiser's records at such reasonable time
38.3 and in such scope as is necessary to enforce the provisions of this chapter.
38.4 Subd. 2. **Retention.** Licensees shall keep a separate work file for each appraisal
38.5 assignment, which is to include copies of all contracts engaging his or her services for
38.6 the real estate appraisal, appraisal reports, and all data, information, and documentation
38.7 assembled and formulated by the appraiser to support the appraiser's opinions and
38.8 conclusions and to show compliance with USPAP, for a period of five years after
38.9 preparation, or at least two years after final disposition of any judicial proceedings in
38.10 which the appraiser provided testimony or was the subject of litigation related to the
38.11 assignment, whichever period expires last. Appropriate work file access and retrieval
38.12 arrangements must be made between any trainee and supervising appraiser if only one
38.13 party maintains custody of the work file.

38.14 Sec. 46. Minnesota Statutes 2008, section 82B.08, is amended by adding a subdivision
38.15 to read:
38.16 Subd. 3a. **Initial application.** The initial application for licensing of a trainee
38.17 real property appraiser must identify the name and address of the supervisory appraiser
38.18 or appraisers. Trainee real property appraisers licensed prior to the effective date of this
38.19 provision must identify the name and address of their supervisory appraiser or appraisers
38.20 at the time of license renewal. A trainee must notify the commissioner in writing within
38.21 ten days of terminating or changing their relationship with any supervisory appraiser.
38.22 The initial application for licensing of a certified residential real property appraiser
38.23 and certified general real property appraiser who intends to act in the capacity of a
38.24 supervisory appraiser must identify the name and address of the trainee real property
38.25 appraiser or appraisers they intend to supervise. A certified residential real property
38.26 appraiser and certified general real property appraiser licensed and acting in the capacity
38.27 of a supervisory appraiser prior to the effective date of this provision must, at the time of
38.28 license renewal, identify the name and address of any trainee real property appraiser or
38.29 appraisers under their supervision.

38.30 Sec. 47. **[82B.093] TRAINEE REAL PROPERTY APPRAISER.**
38.31 (a) A trainee real property appraiser shall be subject to direct supervision by a
38.32 certified residential real property appraiser or certified general real property appraiser in
38.33 good standing.

39.1 (b) A trainee real property appraiser is permitted to have more than one supervising
39.2 appraiser.
39.3 (c) The scope of practice for the trainee real property appraiser classification is the
39.4 appraisal of those properties which the supervising appraiser is permitted by his or her
39.5 current credential and that the supervising appraiser is qualified and competent to appraise.
39.6 (d) A trainee real property appraiser must have a supervisor signature on each
39.7 appraisal that he or she signs, or must be named in the appraisal as providing significant
39.8 real property appraisal assistance to receive credit for experience hours on his or her
39.9 experience log.
39.10 (e) The trainee real property appraiser must maintain copies of appraisal reports he
39.11 or she signed or copies of appraisal reports where he or she was named as providing
39.12 significant real property appraisal assistance.
39.13 (f) The trainee real property appraiser must maintain copies of work files relating to
39.14 appraisal reports he or she signed.
39.15 (g) Separate appraisal logs must be maintained for each supervising appraiser.

39.16 Sec. 48. **[82B.094] SUPERVISION OF TRAINEE REAL PROPERTY**
39.17 **APPRAISERS.**
39.18 (a) A certified residential real property appraiser or a certified general real property
39.19 appraiser, in good standing, may engage a trainee real property appraiser to assist in the
39.20 performance of real estate appraisals, provided that the certified residential real property
39.21 appraiser or a certified general real property appraiser:
39.22 (1) has not been the subject of any license or certificate suspension or revocation or
39.23 has not been prohibited from supervising activities in this state or any other state within
39.24 the previous two years;
39.25 (2) has no more than three trainee real property appraisers working under supervision
39.26 at any one time;
39.27 (3) actively and personally supervises the trainee real property appraiser, which
39.28 includes ensuring that research of general and specific data has been adequately conducted
39.29 and properly reported, application of appraisal principles and methodologies has been
39.30 properly applied, that the analysis is sound and adequately reported, and that any analyses,
39.31 opinions, or conclusions are adequately developed and reported so that the appraisal
39.32 report is not misleading;
39.33 (4) discusses with the trainee real property appraiser any necessary and appropriate
39.34 changes that are made to a report, involving any trainee appraiser, before it is transmitted
39.35 to the client. Changes not discussed with the trainee real property appraiser that are made

40.1 by the supervising appraiser must be provided in writing to the trainee real property
40.2 appraiser upon completion of the appraisal report;
40.3 (5) accompanies the trainee real property appraiser on the inspections of the subject
40.4 properties and drive-by inspections of the comparable sales on all appraisal assignments
40.5 for which the trainee will perform work until the trainee appraiser is determined to be
40.6 competent, in accordance with the competency rule of USPAP for the property type;
40.7 (6) accepts full responsibility for the appraisal report by signing and certifying
40.8 that the report complies with USPAP; and
40.9 (7) reviews and signs the trainee real property appraiser's appraisal report or reports
40.10 or if the trainee appraiser is not signing the report, states in the appraisal the name of the
40.11 trainee and scope of the trainee's significant contribution to the report.
40.12 (b) The supervising appraiser must review and sign the applicable experience log
40.13 required to be kept by the trainee real property appraiser.
40.14 (c) The supervising appraiser must notify the commissioner within ten days when
40.15 the supervision of a trainee real property appraiser has terminated or when the trainee
40.16 appraiser is no longer under the supervision of the supervising appraiser.
40.17 (d) The supervising appraiser must maintain a separate work file for each appraisal
40.18 assignment.
40.19 (e) The supervising appraiser must verify that any trainee real property appraiser that
40.20 is subject to supervision is properly licensed and in good standing with the commissioner.

40.21 Sec. 49. Minnesota Statutes 2008, section 82B.20, subdivision 2, is amended to read:
40.22 Subd. 2. **Conduct prohibited.** No person may:
40.23 (1) obtain or try to obtain a license under this chapter by knowingly making a
40.24 false statement, submitting false information, refusing to provide complete information
40.25 in response to a question in an application for license, or through any form of fraud or
40.26 misrepresentation;
40.27 (2) fail to meet the minimum qualifications established by this chapter;
40.28 (3) be convicted, including a conviction based upon a plea of guilty or nolo
40.29 contendere, of a crime that is substantially related to the qualifications, functions, and
40.30 duties of a person developing real estate appraisals and communicating real estate
40.31 appraisals to others;
40.32 (4) engage in an act or omission involving dishonesty, fraud, or misrepresentation
40.33 with the intent to substantially benefit the license holder or another person or with the
40.34 intent to substantially injure another person;

41.1 (5) engage in a violation of any of the standards for the development or
41.2 communication of real estate appraisals as provided in this chapter;
41.3 (6) fail or refuse without good cause to exercise reasonable diligence in developing
41.4 an appraisal, preparing an appraisal report, or communicating an appraisal;
41.5 (7) engage in negligence or incompetence in developing an appraisal, in preparing
41.6 an appraisal report, or in communicating an appraisal;
41.7 (8) willfully disregard or violate any of the provisions of this chapter or the rules of
41.8 the commissioner for the administration and enforcement of the provisions of this chapter;
41.9 (9) accept an appraisal assignment when the employment itself is contingent upon
41.10 the appraiser reporting a predetermined estimate, analysis, or opinion, or where the fee
41.11 to be paid is contingent upon the opinion, conclusion, or valuation reached, or upon the
41.12 consequences resulting from the appraisal assignment;
41.13 (10) violate the confidential nature of governmental records to which the person
41.14 gained access through employment or engagement as an appraiser by a governmental
41.15 agency;
41.16 (11) offer, pay, or give, and no person shall accept, any compensation or other thing
41.17 of value from a real estate appraiser by way of commission-splitting, rebate, finder's fee,
41.18 or otherwise in connection with a real estate appraisal. This prohibition does not apply
41.19 to transactions among persons licensed under this chapter if the transactions involve
41.20 appraisals for which the license is required;
41.21 (12) engage or authorize a person, except a person licensed under this chapter, to act
41.22 as a real estate appraiser on the appraiser's behalf;
41.23 (13) violate standards of professional practice;
41.24 (14) make an oral appraisal report without also making a written report within a
41.25 reasonable time after the oral report is made;
41.26 (15) represent a market analysis to be an appraisal report;
41.27 (16) give an appraisal in any circumstances where the appraiser has a conflict of
41.28 interest, as determined under rules adopted by the commissioner; or
41.29 (17) engage in other acts the commissioner by rule prohibits.
41.30 No person, including a mortgage originator, appraisal management company, real
41.31 estate broker or salesperson, appraiser, or other licensee, registrant, or certificate holder
41.32 regulated by the commissioner may improperly influence or attempt to improperly
41.33 influence the development, reporting, result, or review of a real estate appraisal. Prohibited
41.34 acts include blacklisting, boycotting, intimidation, coercion, and any other means that
41.35 impairs or may impair the independent judgment of the appraiser, including but not
41.36 limited to the withholding or threatened withholding of payment for an appraisal fee, or

42.1 the conditioning of the payment of any appraisal fee upon the opinion, conclusion, or
42.2 valuation to be reached, or a request that the appraiser report a predetermined opinion,
42.3 conclusion, or valuation, or the desired valuation of any person, or withholding or
42.4 threatening to withhold future work in order to obtain a desired value on a current or
42.5 proposed appraisal assignment.

42.6 Sec. 50. **[325E.3161] TELEPHONE SOLICITATIONS; EXPIRATION**
42.7 **PROVISION.**

42.8 Sections 325E.311 to 325E.316 expire December 31, 2012.

42.9 Sec. 51. Minnesota Statutes 2008, section 471.98, subdivision 2, is amended to read:

42.10 Subd. 2. **Political subdivision.** "Political subdivision" includes a statutory or home
42.11 rule charter city, a county, a school district, a town, a watershed management organization
42.12 as defined in section 103B.205, subdivision 13, or an instrumentality thereof, including
42.13 but not limited to instrumentalities incorporated under chapter 317A, having independent
42.14 policy-making and appropriating authority. For the purposes of this section and section
42.15 471.981, the governing body of a town is the town board. The term also includes the
42.16 Nonprofit Insurance Trust incorporated under chapter 317A and its members incorporated
42.17 under chapter 317A.

42.18 Sec. 52. Minnesota Statutes 2008, section 471.982, subdivision 3, is amended to read:

42.19 Subd. 3. **Exemptions.** Self-insurance pools established and open for enrollment
42.20 on a statewide basis by the Minnesota League of Cities Insurance Trust, the Minnesota
42.21 School Boards Association Insurance Trust, the Minnesota Association of Townships
42.22 Insurance and Bond Trust, ~~or~~ the Minnesota Association of Counties Insurance Trust, or
42.23 the Nonprofit Insurance Trust and the political subdivisions that belong to them are exempt
42.24 from the requirements of this section and section 65B.48, subdivision 3. In addition, the
42.25 Minnesota Association of Townships Insurance and Bond Trust and the townships that
42.26 belong to it are exempt from the requirement to hold the certificate of surety authorization
42.27 issued by the commissioner of commerce as provided in section 574.15.

42.28 Sec. 53. **REPEALER.**

42.29 Minnesota Statutes 2008, sections 60A.201, subdivision 4; 61B.19, subdivision 6;
42.30 70A.07; and 79.56, subdivision 4, are repealed.

42.31 Sec. 54. **EFFECTIVE DATE.**

43.1 (a) Section 25 is effective for all policies with policy years beginning on or after
43.2 May 21, 2009.
43.3 (b) Sections 26 to 30 apply to plans and certificates with an effective date for
43.4 coverage on or after June 1, 2010.
43.5 (c) Sections 39 to 43 are effective the day following final enactment.

60A.201 PLACEMENT OF INSURANCE BY LICENSEE.

Subd. 4. **Lists of unavailable lines of insurance; maintenance.** The commissioner shall maintain on a current basis a list of those lines of insurance for which coverages are believed by the commissioner to be generally unavailable from licensed insurers. The commissioner shall republish a list and make it available to all licensees at least annually. Any person may request in writing that the commissioner add or remove coverage from the current list at the next publication of the list. The commissioner's determinations of coverages to be added to or removed from the list shall not be subject to the Administrative Procedure Act but prior to making determinations the commissioner shall provide opportunity for comment from interested parties.

61B.19 PURPOSE; SCOPE; LIMITATION OF COVERAGE; LIMITATION OF BENEFITS; CONSTRUCTION.

Subd. 6. **Adjustment of liability limits.** The dollar amounts stated in subdivision 4 shall be adjusted for inflation based upon the implicit price deflator for the gross domestic product compiled by the United States Department of Commerce and hereafter referred to as the index. The dollar amounts stated in subdivision 4 are based upon the value of the index for the fourth quarter of 1992, which is the reference base index for purposes of this subdivision. The dollar amounts in subdivision 4 shall change on October 1 of each year after 1993 based upon the percentage difference between the index for the fourth quarter of the preceding year and the reference base index, calculated to the nearest whole percentage point. The commissioner shall announce and publish, on or before April 30 of each year, the changes in the dollar amounts required by this subdivision to take effect on October 1 of that year. The commissioner shall use the most recent revision of the relevant gross domestic product implicit price deflators available as of April 1. If the United States Department of Commerce changes the base year for the gross domestic product implicit price deflator, the commissioner shall make the calculations necessary to convert from the old to the new base year. Changes must be in increments of $10,000. No adjustment may be made until the change in the index results in at least a $10,000 increase.

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.