A bill for an act

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

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

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

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

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

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

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

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:

(1) warranties;

(2) maintenance agreements;

(3) warranties, service contracts, or maintenance agreements offered by public utilities, as defined in section 216B.02, subdivision 4, or an entity or operating unit owned by or under common control with a public utility;

(4) service contracts sold or offered for sale to persons other than consumers;

(5) service contracts on tangible property where the tangible property for which the service contract is sold has a purchase price of $250 or less, exclusive of sales tax;

(6) service contracts for home security equipment installed by a licensed technology systems contractor; and

(7) motor club membership contracts that typically provide roadside assistance services to motorists stranded for reasons that include, but are not limited to, mechanical breakdown or adverse road conditions.

(c) The types of agreements referred to in paragraph (b) are not subject to chapters 60A to 79A, except as otherwise specifically provided by law.

(d) Service contracts issued by motor vehicle manufacturers covering private passenger automobiles are only subject to sections 59B.03, subdivision 5, 59B.05, and 59B.07.

(e) All warranty service contracts are deemed to be made in Minnesota for the purpose of arbitration.

Sec. 6. Minnesota Statutes 2008, section 60A.08, is amended by adding a subdivision to read:

Subd. 15. **Classification of insurance filings data.** (1) All forms, rates, and related information filed with the commissioner under section 61A.02 shall be nonpublic until the filing becomes effective.

(2) All forms, rates, and related information filed with the commissioner under section 62A.02 shall be nonpublic until the filing becomes effective.

(3) All forms, rates, and related information filed with the commissioner under section 62C.14, subdivision 10, shall be nonpublic until the filing becomes effective.

(4) All forms, rates, and related information filed with the commissioner under section 70A.06 shall be nonpublic until the filing becomes effective.

(5) All forms, rates, and related information filed with the commissioner under section 79.56 shall be nonpublic until the filing becomes effective.

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:

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

Sec. 11. Minnesota Statutes 2008, section 60A.2085, subdivision 1, is amended to read:

Subdivision 1. **Association created; duties.** There is hereby created a nonprofit association to be known as the Surplus Lines Association of Minnesota. The association is not a state agency for purposes of chapter 16A, 16B, 16C, or 43A. All surplus lines licensees are members of this association. Section 60A.208~~, subdivision 5,~~ does not apply to the association created pursuant to the provisions of this section. The association shall perform its functions under the plan of operation established under subdivision 3 and must exercise its powers through a board of directors established under subdivision 2 as set forth in the plan of operation. The association shall be authorized and have the duty to:

(1) receive, record, and stamp all surplus lines insurance documents that surplus lines licensees are required to file with the association;

(2) prepare and deliver monthly to the commissioners of revenue and commerce a report regarding surplus lines business. The report must include a list of all the business procured during the preceding month, in the form the commissioners prescribe;

(3) educate its members regarding the surplus lines law of this state including insurance tax responsibilities and the rules and regulations of the commissioners of revenue and commerce relative to surplus lines insurance;

(4) communicate with organizations of agents, brokers, and admitted insurers with respect to the proper use of the surplus lines market;

(5) employ and retain persons necessary to carry out the duties of the association;

(6) borrow money necessary to effect the purposes of the association and grant a security interest or mortgage in its assets, including the stamping fees charged pursuant to subdivision 7 in order to secure the repayment of any such borrowed money;

(7) enter contracts necessary to effect the purposes of the association;

(8) provide other services to its members that are incidental or related to the purposes of the association; ~~and~~

(9) form and organize itself as a nonprofit corporation under chapter 317A, with the powers set forth in section 317A.161 that are not otherwise limited by this section or in its articles, bylaws, or plan of operation;

(10) file such applications and take such other action as necessary to establish and maintain the association as tax exempt pursuant to the federal income tax code;

(11) recommend to the commissioner of commerce revisions to Minnesota law relating to the regulation of surplus lines insurance in order to improve the efficiency and effectiveness of that regulation; and

~~(9)~~ (12) take other actions reasonably required to implement the provisions of this section.

Sec. 12. Minnesota Statutes 2008, section 60A.2085, subdivision 3, is amended to read:

Subd. 3. **Plan of operation.** (a) The plan of operation shall provide for the formation, operation, and governance of the association as a nonprofit corporation under chapter 317A. The plan of operation must provide for the election of a board of directors by the members of the association. The board of directors shall elect officers as provided for in the plan of operation. The plan of operation shall establish the manner of voting and may weigh each member's vote to reflect the annual surplus lines insurance premium written by the member. Members employed by the same or affiliated employers may consolidate their premiums written and delegate an individual officer or partner to represent the member in the exercise of association affairs, including service on the board of directors.

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

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

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

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

Sec. 13. Minnesota Statutes 2008, section 60A.2085, subdivision 7, is amended to read:

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

Sec. 14. Minnesota Statutes 2008, section 60A.2085, subdivision 8, is amended to read:

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

Sec. 15. Minnesota Statutes 2008, section 60A.23, subdivision 8, is amended to read:

Subd. 8. **Self-insurance or insurance plan administrators who are vendors of risk management services.** (1) **Scope.** This subdivision applies to any vendor of risk management services and to any entity which administers, for compensation, a self-insurance or insurance plan. This subdivision does not apply (a) to an insurance company authorized to transact insurance in this state, as defined by section 60A.06, subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for its employees' benefits; (e) to an entity which administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions; or (f) to an entity which administers a self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance to the plan and if the licensed insurer has appointed the entity administering the plan as one of its licensed agents within this state.

(2) **Definitions.** For purposes of this subdivision the following terms have the meanings given them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) $4,000 times the number of group members;

(ii) 120 percent of expected claims; or

(iii) $20,000; or

(3) has an aggregate attachment point for groups of 51 or more that is lower than 110 percent of expected claims.

(b) An insurer shall determine the number of persons in a group, for the purposes of this section, on a consistent basis, at least annually. Where the insurance policy or evidence of coverage applies to a contract period of more than one year, the dollar amounts set forth in paragraph (a), clauses (1) and (2), must be multiplied by the length of the contract period expressed in years.

(c) The commissioner may adjust the constant dollar amounts provided in paragraph (a), clauses (1) ~~and~~, (2), and (3), on January 1 of any year, based upon changes in the medical component of the Consumer Price Index (CPI). Adjustments must be in increments of $100 and must not be made unless at least that amount of adjustment is required. The commissioner shall publish any change in these dollar amounts at least ~~three~~ six months before their effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) where no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be ~~$300,000~~ $500,000 in present value;

(5) in no event shall the association be liable to expend more than ~~$300,000~~ $500,000 in the aggregate with respect to any one life under clause (2), items (i), (ii), (iii), (iv), and clause (4), and any one individual under clause (3);

(6) in no event shall the association be liable to expend more than ~~$7,500,000~~ $10,000,000 with respect to all unallocated annuities of a retirement plan, except a defined benefit plan, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992. If total claims from a plan exceed ~~$7,500,000~~ $10,000,000, the ~~$7,500,000~~ $10,000,000 shall be prorated among the claimants;

(7) for purposes of applying clause (2)(ii) and clause (5), with respect only to health insurance benefits, the term "any one life" applies to each individual covered by a health insurance policy;

(8) where covered contractual obligations are equal to or less than the limits stated in this subdivision, the association will pay the difference between the covered contractual obligations and the amount credited by the estate of the insolvent or impaired insurer, if that amount has been determined or, if it has not, the covered contractual limit, subject to the association's right of subrogation;

(9) where covered contractual obligations exceed the limits stated in this subdivision, the amount payable by the association will be determined as though the covered contractual obligations were equal to those limits. In making the determination, the estate shall be deemed to have credited the covered person the same amount as the estate would credit a covered person with contractual obligations equal to those limits; or

(10) the following illustrates how the principles stated in clauses (8) and (9) apply. The example illustrated concerns hypothetical claims subject to the limit stated in clause (2)(iii). The principles stated in clauses (8) and (9), and illustrated in this clause, apply to claims subject to any limits stated in this subdivision.

CONTRACTUAL OBLIGATIONS OF:

$50,000

| | Estate | Guaranty Association |
|---|---|---|
| 0% recovery from estate | $ 0 | $ 50,000 |
| 25% recovery from estate | $ 12,500 | $ 37,500 |
| 50% recovery from estate | $ 25,000 | $ 25,000 |

| | | |
|---|---|---|
| 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

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

Sec. 20. Minnesota Statutes 2008, section 61B.28, subdivision 8, is amended to read:

Subd. 8. **Form.** The form of notice referred to in subdivision 7, paragraph (a), is as follows:

".....

.....

.....

(insert name, current address, and
telephone number of insurer)

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

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

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

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

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

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

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

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

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

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

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

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

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

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

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

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

(8) accident-only coverage;

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

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

(11) workers' compensation insurance; or

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

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

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

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

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

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

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

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

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

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

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

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

(2) shall not discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to such individual.

(b) Nothing in paragraph (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(1) denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

(c) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(d) Paragraph (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under Part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996 as they may be revised from time to time, and consistent with paragraph (a).

(e) For purposes of carrying out paragraph (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(f) Notwithstanding paragraph (c), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions are met:

(1) The request is made pursuant to research that complies with Code of Federal Regulations title 45, part 46, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(i) compliance with the request is voluntary; and

(ii) noncompliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this paragraph shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the secretary may by regulation require for activities under this paragraph.

(g) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(i) An issuer of a Medicare supplement policy or certificate that obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (h) if such request, requirement, or purchase is not in violation of paragraph (g).

(j) For purposes of this subdivision only:

(1) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(2) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic test of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such terms includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term genetic information does not include information about the sex or age of any individual.

(3) "Genetic services" means a genetic test or genetic counseling, including obtaining, interpreting, or assessing genetic information or genetic education.

(4) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term

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

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

(6) "Underwriting purposes" means:

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

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

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

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

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

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

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

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

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

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

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country; and prescription drug expenses, not covered by Medicare. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare 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:~~

~~(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:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 screening including mammograms and pap smears; ~~and~~

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

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

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

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

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

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

(3) coverage for all of the Medicare Part B annual deductible; and

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

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

~~(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;~~

~~(III) $1,600 per calendar year;~~

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

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

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

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

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

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

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

~~(B) care provided by family members, unpaid volunteers, or providers who are not care providers;~~

~~(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4). An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006.~~

Sec. 28. **[62A.3163] MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT PART A DEDUCTIBLE COVERAGE.**

The Medicare supplement plan with 50 percent Part A deductible coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible under Medicare Part A;

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

(5) coverage under Medicare Part A or B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for 100 percent of the Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

Sec. 29. **[62A.3164] MEDICARE SUPPLEMENT PLAN WITH $20 AND $50 CO-PAYMENT MEDICARE PART B COVERAGE.**

The Medicare supplement plan with $20 and $50 co-payment Medicare Part B coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible under Medicare Part A;

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

(5) coverage for Medicare Part A or B of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B except for the lesser of $20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit and the lesser of $50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit; however, this

co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

Sec. 30. **[62A.3165] MEDICARE SUPPLEMENT PLAN WITH HIGH DEDUCTIBLE COVERAGE.**

The Medicare supplement plan will pay 100 percent coverage upon payment of the annual high deductible. The annual deductible shall consist of out-of-pocket expenses, other than premiums, for services covered. This plan must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for 100 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible under Medicare Part A;

(4) coverage for 100 percent of cost sharing for all Medicare Part A eligible expenses and respite care;

(5) coverage for 100 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) except for coverage provided in this clause, coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

(8) coverage of 100 percent of the hospital and medical expenses and supplies incurred during travel outside of the United States as a result of a medical emergency;

(9) coverage for 100 percent of Medicare Part A and B home health care services and medical supplies; and

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

Sec. 31. Minnesota Statutes 2008, section 62L.02, subdivision 26, is amended to read:

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

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

section 62L.045, with respect to small employers in the association, even though the association also provides coverage to its members that do not qualify as small employers.

(c) If an employer has employees covered under a trust specified in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

Sec. 32. Minnesota Statutes 2008, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital ~~and a written~~ as applicable. Written notification must also be sent to the hospital~~,~~ as applicable and attending health care professional~~, and enrollee~~ if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic

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

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

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2008, section 72A.20, subdivision 15, is amended to read:

Subd. 15. **Practices not held to be discrimination or rebates.** Nothing in subdivision 8, 9, or 10, or in section 72A.12, subdivisions 3 and 4, shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) in the case of any contract of life insurance or annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(2) in the case of life insurance policies issued on the industrial debit plan, making allowance, to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer, in an amount which fairly represents the saving in collection expense;

(3) readjustment of the rate of premium for a group insurance policy based on the loss or expense experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(4) in the case of an individual or group health insurance policy, the payment of differing amounts of reimbursement to insureds who elect to receive health care goods or services from providers designated by the insurer~~, provided that each insurer shall on or before August 1 of each year file with the commissioner summary data regarding the financial reimbursement offered to providers so designated.~~; and

~~Any insurer which proposes to offer an arrangement authorized under this clause shall disclose prior to its initial offering and on or before August 1 of each year thereafter as a supplement to its annual statement submitted to the commissioner pursuant to section 60A.13, subdivision 1, the following information:~~

~~(a) the name which the arrangement intends to use and its business address;~~

~~(b) the name, address, and nature of any separate organization which administers the arrangement on the behalf of the insurers; and~~

~~(c) the names and addresses of all providers designated by the insurer under this clause and the terms of the agreements with designated health care providers.~~

~~The commissioner shall maintain a record of arrangements proposed under this clause, including a record of any complaints submitted relative to the arrangements.~~

(5) in the case of an individual or group health insurance policy, offering incentives to individuals for taking part in preventive health care services, medical management incentive programs, or activities designed to improve the health of the individual.

If the commissioner requests copies of contracts with a provider under ~~this~~ clause (4) and the provider requests a determination, all information contained in the contracts that the commissioner determines may place the provider or health care plan at a competitive disadvantage is nonpublic data.

Sec. 37. Minnesota Statutes 2008, section 72A.20, subdivision 26, is amended to read:

Subd. 26. **Loss experience.** An insurer shall without cost to the insured provide an insured with the loss or claims experience of that insured for the current policy period and for the two policy periods preceding the current one for which the insurer has provided coverage, within 30 days of a request for the information by the policyholder. Whenever reporting loss experience data, actual claims paid on behalf of the insured must be reported separately from claims incurred but not paid, pooling charges for catastrophic claim protection, and any other administrative fees or charges that may be charged as an incurred claim expense. Claims experience data must be provided to the insured in accordance with state and federal requirements regarding the confidentiality of medical data. The insurer shall not be responsible for providing information without cost more often than once in a 12-month period. The insurer is not required to provide the information if the policy covers the employee of more than one employer and the information is not maintained separately for each employer and not all employers request the data.

An insurer, health maintenance organization, or a third-party administrator may not request more than three years of loss or claims experience as a condition of submitting an application or providing coverage.

This subdivision only applies to group life policies and group health policies.

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

Sec. 38. **[72A.204] PROHIBITED USES OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS.**

Subdivision 1. **Purpose and scope.** The purpose of this section is to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in:

(1) the solicitation, sale, or purchase of a life insurance or annuity product; or

(2) the provision of advice in connection with the solicitation, sale, or purchase of a life insurance or annuity product.

Subd. 2. **Insurance producer.** For purposes of this section, "insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, including annuities.

Subd. 3. **Prohibited uses of senior-specific certifications and professional designations.** (a) It is an unfair and deceptive act or practice in the business of insurance for an insurance producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a client or prospective client that the insurance producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale, or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly, including the provision of advice through publications or writings or by issuing or promulgating analyses or reports related to a life insurance or annuity product.

(b) The prohibited use of senior-specific certifications or professional designations includes, but is not limited to, the following:

(1) use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use such certification or designation;

(2) use of a nonexistent or self-conferred certification or professional designation;

(3) use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the insurance producer using the certification or designation does not have; and

(4) use of a certification or professional designation that was obtained from a certifying or designating organization that:

(i) is primarily engaged in the business of instruction in sales or marketing;

(ii) does not have reasonable standards or procedures for ensuring the competency of its certificants or designees;

(iii) does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or

(iv) does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

(c) There is a rebuttable presumption that a certifying or designating organization is not disqualified solely for the purposes of paragraph (b), clause (4), when the certification or designation issued from the organization does not primarily apply to sales or marketing

and when the organization or the certification or designation in question has been accredited by:

(1) the American National Standards Institute (ANSI);

(2) the National Commission for Certifying Agencies; or

(3) any organization that is on the United States Department of Education list entitled "Accrediting Agencies Recognized for Title IV Purposes."

(d) In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered must include:

(1) use of one or more words such as "senior," "retirement," "elder," or like words combined with one or more words such as "certified," "registered," "chartered," "adviser," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

(2) the manner in which those words are combined.

(e) For purposes of this section, a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency is not a certification or professional designation, unless it is used in a manner that would confuse or mislead a reasonable consumer, when the job title:

(1) indicates seniority or standing within the organization; or

(2) specifies an individual's area of specialization within the organization.

(f) For purposes of paragraph (e), "financial services regulatory agency" includes, but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

Sec. 39. Minnesota Statutes 2008, section 79A.04, subdivision 1, is amended to read:

Subdivision 1. **Annual securing of liability.** Each year every private self-insuring employer shall secure incurred liabilities for the payment of compensation and the performance of its obligations and the obligations of all self-insuring employers imposed under chapter 176 by renewing the prior year's security deposit or by making a new deposit of security. If a new deposit is made, it must be posted ~~within 60 days of the filing of the self-insured employer's annual report with the commissioner, but in no event later than July 1~~ in the following manner: within 60 days of the filing of the annual report, the security posting for all prior years plus one-third of the posting for the current year; by

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subdivision 1. **Examination of records.** The commissioner may make examinations within or without this state of each real estate appraiser's records at such reasonable time and in such scope as is necessary to enforce the provisions of this chapter.

Subd. 2. **Retention.** Licensees shall keep a separate work file for each appraisal assignment, which is to include copies of all contracts engaging his or her services for the real estate appraisal, appraisal reports, and all data, information, and documentation assembled and formulated by the appraiser to support the appraiser's opinions and conclusions and to show compliance with USPAP, for a period of five years after preparation, or at least two years after final disposition of any judicial proceedings in which the appraiser provided testimony or was the subject of litigation related to the assignment, whichever period expires last. Appropriate work file access and retrieval arrangements must be made between any trainee and supervising appraiser if only one party maintains custody of the work file.

Sec. 46. Minnesota Statutes 2008, section 82B.08, is amended by adding a subdivision to read:

Subd. 3a. **Initial application.** The initial application for licensing of a trainee real property appraiser must identify the name and address of the supervisory appraiser or appraisers. Trainee real property appraisers licensed prior to the effective date of this provision must identify the name and address of their supervisory appraiser or appraisers at the time of license renewal. A trainee must notify the commissioner in writing within ten days of terminating or changing their relationship with any supervisory appraiser.

The initial application for licensing of a certified residential real property appraiser and certified general real property appraiser who intends to act in the capacity of a supervisory appraiser must identify the name and address of the trainee real property appraiser or appraisers they intend to supervise. A certified residential real property appraiser and certified general real property appraiser licensed and acting in the capacity of a supervisory appraiser prior to the effective date of this provision must, at the time of license renewal, identify the name and address of any trainee real property appraiser or appraisers under their supervision.

Sec. 47. **[82B.093] TRAINEE REAL PROPERTY APPRAISER.**

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

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

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

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

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

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

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

Sec. 48. **[82B.094] SUPERVISION OF TRAINEE REAL PROPERTY APPRAISERS.**

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

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

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

(3) actively and personally supervises the trainee real property appraiser, which includes ensuring that research of general and specific data has been adequately conducted and properly reported, application of appraisal principles and methodologies has been properly applied, that the analysis is sound and adequately reported, and that any analyses, opinions, or conclusions are adequately developed and reported so that the appraisal report is not misleading;

(4) discusses with the trainee real property appraiser any necessary and appropriate changes that are made to a report, involving any trainee appraiser, before it is transmitted to the client. Changes not discussed with the trainee real property appraiser that are made

by the supervising appraiser must be provided in writing to the trainee real property appraiser upon completion of the appraisal report;

(5) accompanies the trainee real property appraiser on the inspections of the subject properties and drive-by inspections of the comparable sales on all appraisal assignments for which the trainee will perform work until the trainee appraiser is determined to be competent, in accordance with the competency rule of USPAP for the property type;

(6) accepts full responsibility for the appraisal report by signing and certifying that the report complies with USPAP; and

(7) reviews and signs the trainee real property appraiser's appraisal report or reports or if the trainee appraiser is not signing the report, states in the appraisal the name of the trainee and scope of the trainee's significant contribution to the report.

(b) The supervising appraiser must review and sign the applicable experience log required to be kept by the trainee real property appraiser.

(c) The supervising appraiser must notify the commissioner within ten days when the supervision of a trainee real property appraiser has terminated or when the trainee appraiser is no longer under the supervision of the supervising appraiser.

(d) The supervising appraiser must maintain a separate work file for each appraisal assignment.

(e) The supervising appraiser must verify that any trainee real property appraiser that is subject to supervision is properly licensed and in good standing with the commissioner.

Sec. 49. Minnesota Statutes 2008, section 82B.20, subdivision 2, is amended to read:

Subd. 2. **Conduct prohibited.** No person may:

(1) obtain or try to obtain a license under this chapter by knowingly making a false statement, submitting false information, refusing to provide complete information in response to a question in an application for license, or through any form of fraud or misrepresentation;

(2) fail to meet the minimum qualifications established by this chapter;

(3) be convicted, including a conviction based upon a plea of guilty or nolo contendere, of a crime that is substantially related to the qualifications, functions, and duties of a person developing real estate appraisals and communicating real estate appraisals to others;

(4) engage in an act or omission involving dishonesty, fraud, or misrepresentation with the intent to substantially benefit the license holder or another person or with the intent to substantially injure another person;

(5) engage in a violation of any of the standards for the development or communication of real estate appraisals as provided in this chapter;

(6) fail or refuse without good cause to exercise reasonable diligence in developing an appraisal, preparing an appraisal report, or communicating an appraisal;

(7) engage in negligence or incompetence in developing an appraisal, in preparing an appraisal report, or in communicating an appraisal;

(8) willfully disregard or violate any of the provisions of this chapter or the rules of the commissioner for the administration and enforcement of the provisions of this chapter;

(9) accept an appraisal assignment when the employment itself is contingent upon the appraiser reporting a predetermined estimate, analysis, or opinion, or where the fee to be paid is contingent upon the opinion, conclusion, or valuation reached, or upon the consequences resulting from the appraisal assignment;

(10) violate the confidential nature of governmental records to which the person gained access through employment or engagement as an appraiser by a governmental agency;

(11) offer, pay, or give, and no person shall accept, any compensation or other thing of value from a real estate appraiser by way of commission-splitting, rebate, finder's fee, or otherwise in connection with a real estate appraisal. This prohibition does not apply to transactions among persons licensed under this chapter if the transactions involve appraisals for which the license is required;

(12) engage or authorize a person, except a person licensed under this chapter, to act as a real estate appraiser on the appraiser's behalf;

(13) violate standards of professional practice;

(14) make an oral appraisal report without also making a written report within a reasonable time after the oral report is made;

(15) represent a market analysis to be an appraisal report;

(16) give an appraisal in any circumstances where the appraiser has a conflict of interest, as determined under rules adopted by the commissioner; or

(17) engage in other acts the commissioner by rule prohibits.

No person, including a mortgage originator, appraisal management company, real estate broker or salesperson, appraiser, or other licensee, registrant, or certificate holder regulated by the commissioner may improperly influence or attempt to improperly influence the development, reporting, result, or review of a real estate appraisal. Prohibited acts include blacklisting, boycotting, intimidation, coercion, and any other means that impairs or may impair the independent judgment of the appraiser, including but not limited to the withholding or threatened withholding of payment for an appraisal fee, or

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

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

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

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

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

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

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

Sec. 53. **REPEALER.**

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

Sec. 54. **EFFECTIVE DATE.**

(a) Section 25 is effective for all policies with policy years beginning on or after May 21, 2009.

(b) Sections 26 to 30 apply to plans and certificates with an effective date for coverage on or after June 1, 2010.

(c) Sections 39 to 43 are effective the day following final enactment.