CHAPTER 330—H.F.No. 1155

An act relating to insurance; life and health; regulating policy and contract provisions, coverages, certain cost-containment mechanisms, cancellations and nonrenewals, trade and marketing practices, and remedies in these and other lines; making technical changes; amending Minnesota Statutes 1988, sections 45.025, subdivision 8; 45.027, subdivision 7; 45.028, subdivision 1; 61A.011, subdivision 1; 61A.09, by adding a subdivision; 61A.092, subdivision 3; 61B.03, subdivision 6; 62A.01; 62A.041; 62A.08; 62A.09; 62A.15, subdivisions 3a and 4; 62A.152, subdivisions 2 and 3; 62A.17, subdivision 2; 62A.46, by adding a subdivision; 62A.48, subdivision 1; 62B.01; 62B.04, subdivision 1; 62D.12, by adding a subdivision; 62E.06, subdivision 1; 65B.525, subdivision 1; 72A.20, subdivision 15, and by adding subdivisions; and 149.11; proposing coding for new law in Minnesota Statutes, chapters 62A; 65A; and 72A; repealing Minnesota Statutes 1988, sections 60A.23, subdivision 7; and 72A.13, subdivision 2.

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

Section 1. Minnesota Statutes 1988, section 45.025, subdivision 8, is amended to read:

Subd. 8. **CIVIL REMEDY.** A person violating this section is liable to a purchaser of the investment product. The purchaser may sue either in equity for rescission upon tender of the investment product or at law for damages if the purchaser no longer owns the investment product. In an action for rescission, the purchaser is entitled to recover the consideration paid for the investment product, together with interest at the legal rate, costs, and reasonable attorney fees, less the amount of any income received on the investment product. In an action at law, damages are the consideration paid for the investment product together with interest at the legal rate to the date of disposition, costs, and reasonable attorney fees, less the value of the investment product at the date of disposition. Subject to the exceptions in subdivision 3, if the advertisement advertises an investment product whose interest rate varies according to the earnings or income of the issuer and if the advertisement projects the accumulated earnings for a period longer than one year, the issuer and agent are jointly and severally liable to the purchaser for the difference in the principal and interest received by the purchaser and the principal and interest as projected in the advertisement.

Sec. 2. Minnesota Statutes 1988, section 45.027, subdivision 7, is amended to read:

Subd. 7. **ACTIONS AGAINST LICENSEES.** In addition to any other actions authorized by this section, the commissioner may, by order, deny, suspend, or revoke the authority or license of a person subject to chapters 45 to 83, 155A, 309, or 332, or censure that person if the commissioner finds that:

(1) the order is in the public interest; ~~or~~ and

(2) the person has violated chapters 45 to 83, 155A, 309, or 332.

Sec. 3. Minnesota Statutes 1988, section 45.028, subdivision 1, is amended to read:

Subdivision 1. **REQUIREMENT.** (a) When a person, including any nonresident of this state, engages in conduct prohibited or made actionable by chapters 45 to 83, 155A, 309, and 332, or any rule or order under those chapters, and the person has not filed a consent to service of process under chapters 45 to 83, 155A, 309, and 332, that conduct is equivalent to an appointment of the commissioner as the person's attorney to receive service of process in any noncriminal suit, action, or proceeding against the person which is based on that conduct and is brought under chapters 45 to 83, 155A, 309, and 332, or any rule or order under those chapters.

(b) Subdivision 2 also applies in all other cases under chapters 45 to 83, 155A, 309, and 332, or any rule or order under those chapters, in which a person, including a nonresident of this state, has filed a consent to service of process. This paragraph supersedes any inconsistent provision of law.

Sec. 4. Minnesota Statutes 1988, section 61A.011, subdivision 1, is amended to read:

Subdivision 1. Notwithstanding any other provision of law when any insurer, including a fraternal benefit society, admitted to transact life insurance in this state pays the proceeds of or payments under any policy of life insurance, individual or group, such insurer shall pay interest at a rate not less than the then current rate of interest on death proceeds left on deposit with the insurer, computed from the insured's death until the date of payment, on any such proceeds or payments payable to a beneficiary residing in this state, or to a beneficiary under a policy issued in this state or to a beneficiary under a policy insuring a person resident in this state at the time of death. If the insurer has no established current rate of interest for death proceeds left on deposit with the insurer, then the rate of interest to be paid under this subdivision shall be the rate of interest charged by the insurer to policy holders for loans under the insurer's policies.

Sec. 5. Minnesota Statutes 1988, section 61A.09, is amended by adding a subdivision to read:

Subd. 3. Group life insurance policies may be issued to cover groups of not less than ten debtors of a creditor written under a master policy issued to a creditor to insure its debtors in connection with real estate mortgage loans, in an amount not to exceed the actual or scheduled amount of their indebtedness. Each application for group mortgage insurance offered prior to or at the time of loan closing shall contain a clear and conspicuous notice that the insurance is optional and is not a condition for obtaining the loan. Each person insured under a group insurance policy issued under this subdivision shall be furnished a certificate of insurance which conforms to the requirements of section 62B.06, subdivision 2, and which includes a conversion privilege permitting an insured debtor to convert, without evidence of insurability, to an individual policy of

decreasing term insurance within 30 days of the date the insured debtor's group coverage is terminated for any reason other than the nonpayment of premiums. The initial amount of coverage under the individual policy shall be an amount equal to the amount of coverage terminated under the group policy and shall decrease over a term that corresponds with the scheduled term of the insured debtor's mortgage loan. The premium for the individual policy shall be the same premium the insured debtor was paying under the group policy.

Sec. 6. Minnesota Statutes 1988, section 61A.092, subdivision 3, is amended to read:

Subd. 3. **NOTICE OF OPTIONS.** Upon termination of or layoff from employment of a covered employee, the employer shall inform the employee of:

(1) the employee's right to elect to continue the coverage;

(2) the amount the employee must pay monthly to the employer to retain the coverage;

(3) the manner in which and the office of the employer to which the payment to the employer must be made; and

(4) the time by which the payments to the employer must be made to retain coverage.

The employee has 60 days within which to elect coverage. The 60-day period shall begin to run on the date coverage would otherwise terminate or on the date upon which notice of the right to coverage is received, whichever is later.

Notice must be in writing and sent by first class ~~certified~~ mail to the employee's last known address which the employee has provided to the employer.

A notice in substantially the following form is sufficient: "As a terminated or laid off employee, the law authorizes you to maintain your group insurance benefits for a period of up to 18 months. To do so, you must notify your former employer within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... at ..... by the ..... of each month."

Sec. 7. Minnesota Statutes 1988, section 61B.03, subdivision 6, is amended to read:

Subd. 6. **COVERED POLICY.** "Covered policy" means any policy or contract owned by a Minnesota resident to which sections 61B.01 to 61B.16 apply, as provided in section 61B.02.

Sec. 8. Minnesota Statutes 1988, section 62A.01, is amended to read:

62A.01 **POLICY OF ACCIDENT AND SICKNESS INSURANCE ~~DEFINED~~.**

Subdivision 1. **DEFINITION.** The term "policy of accident and sickness insurance" as used herein includes any policy covering the kind of insurance described in section 60A.06, subdivision 1, clause (5)(a).

Subd. 2. **EQUAL PROTECTION.** A certificate of insurance or similar evidence of coverage issued to a Minnesota resident shall provide coverage for all benefits required to be covered in group policies in Minnesota by chapters 62A and 62E.

This subdivision supersedes any inconsistent provision of chapters 62A and 62E.

A policy of accident and sickness insurance that is issued or delivered in this state and that covers a person residing in another state may provide coverage or contain provisions that are less favorable to that person than required by chapters 62A and 62E. Less favorable coverages or provisions must meet the requirements that the state in which the person resides would have required had the policy been issued or delivered in that state.

Subd. 3. **EXCLUSIONS.** Subdivision 2 does not apply to certificates issued in regard to a master policy issued outside the state of Minnesota if all of the following are true:

(1) the policyholder or certificate holder exists primarily for purposes other than to obtain insurance;

(2) the policyholder or certificate holder is not a Minnesota corporation and does not have its principal office in Minnesota;

(3) the policy or certificate covers fewer than 25 employees who are residents of Minnesota and the Minnesota employees represent less than 25 percent of all covered employees; and

(4) on request of the commissioner, the issuer files with the commissioner a copy of the policy and a copy of each form of certificate.

This subdivision applies to employers who are not corporations if they are policyholders or certificate holders providing coverage to employees through the certificate or policy.

Subd. 4. **APPLICATION OF OTHER LAWS.** Section 60A.08, subdivision 4, shall not be construed as requiring a certificate of insurance or similar evidence of insurance that meets the conditions of subdivision 3 to comply with chapter 62A or 62E.

Sec. 9. Minnesota Statutes 1988, section 62A.041, is amended to read:

62A.041 **MATERNITY BENEFITS.**

Subdivision 1. **DISCRIMINATION PROHIBITED AGAINST UNMAR-**

RIED WOMEN. Each group policy of accident and health insurance and each group health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy and each group contract shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy and each individual contract shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Subd. 2. **LIMITATION ON COVERAGE PROHIBITED.** Each group policy of accident and health insurance, except for policies which only provide coverage for specified diseases, or each group subscriber contract of accident and health insurance or health maintenance contract, issued or renewed after August 1, 1987, shall include maternity benefits in the same manner as any other illness covered under the policy or contract.

Subd. 3. **ABORTION.** For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

This section applies to policies and contracts issued, delivered, or renewed after August 1, 1985, that cover Minnesota residents.

Sec. 10. **[62A.049] LIMITATION ON PREAUTHORIZATIONS.**

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or part of the insured's benefits. This provision does not apply to admissions for treatment of chemical dependency and nervous and mental disorders.

Sec. 11. Minnesota Statutes 1988, section 62A.08, is amended to read:

62A.08 **COVERAGE OF POLICY, CONTINUANCE IN FORCE.**

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, ~~the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.~~ the policy would not have been issued, the insurer may, within 90 days of discovering the misstatement, limit its liability to a refund of all premiums paid. In all other instances the insurer may either adjust the premium to reflect the actual age of the insured or adjust the benefits to reflect the actual age and the premium.

Sec. 12. Minnesota Statutes 1988, section 62A.09, is amended to read:

62A.09 **LIMITATION.**

Nothing in sections 62A.01 ~~to~~, 62A.02, 62A.03, 62A.04, 62A.05, 62A.06, 62A.07, and 62A.08 shall apply to or affect:

(1) any policy of workers' compensation insurance or any policy of casualty or fire and allied lines insurance with or without supplementary coverage therein; or

(2) any policy or contract of reinsurance; or

(3) any ~~blanket or~~ group policy of insurance, except when specifically referred to; or

(4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

Sec. 13. Minnesota Statutes 1988, section 62A.15, subdivision 3a, is amended to read:

Subd. 3a. **NURSING SERVICES.** All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a duly licensed physician must include services provided by a registered nurse who is licensed pursuant to section 148.171 and who is certified by the profession to engage in advanced nursing practice. "Advanced

nursing practice" means the performance of health services by professional nurses who have gained additional knowledge and skills through an organized program of study and clinical experience preparing nurses for advanced practice roles as nurse anesthetists, nurse midwives, nurse practitioners, or clinical specialists in psychiatric or mental health nursing. The program of study must be beyond the education required for registered nurse licensure and must meet criteria established by the professional nursing organization having authority to certify the registered nurse in advanced nursing practice~~, and appear on a list established and maintained by the board of nursing through rulemaking~~. For the purposes of this subdivision, the board of nursing shall, by rule, adopt a list of professional nursing organizations which have the authority to certify nurses in advanced nursing practice.

This subdivision is intended to provide payment of benefits for treatment and services by a licensed registered nurse certified in advanced nursing practice as defined in this subdivision and is not intended to add to the benefits provided for in these policies or contracts.

Sec. 14. Minnesota Statutes 1988, section 62A.15, subdivision 4, is amended to read:

Subd. 4. **DENIAL OF BENEFITS.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, licensed optometrist, or a registered nurse meeting the requirements of subdivision 3a.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic ~~licensed under the provisions of sections 148.01 to 148.104~~.

Sec. 15. Minnesota Statutes 1988, section 62A.152, subdivision 2, is amended to read:

Subd. 2. **MINIMUM BENEFITS.** (a) All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage on the same basis as coverage for other benefits for at least 80 percent of the cost of the usual and customary charges of the first ten hours of treatment incurred over a 12-month benefit period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, and at least 75 percent of the cost of the usual and customary charges for any additional hours of treatment during the same 12-month benefit period for serious or persistent mental or nervous disorders, if the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of human services or other authorized state agency, ~~or~~ (3) a licensed psychologist licensed

under the provisions of sections 148.88 to 148.98, (4) a licensed consulting psychologist licensed under the provisions of sections 148.88 to 148.98, or (5) a psychiatrist licensed under chapter 147. Prior authorization from an accident and health insurance company, or a nonprofit health service corporation, shall be required for an extension of coverage beyond ten hours of treatment. This prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may be limited to a maximum of 30 visit hours during any 12-month benefit period.

(b) For purposes of this section, covered treatment for a minor includes treatment for the family if family therapy is recommended by a provider listed in paragraph (a), ~~item (1), (2), or (3)~~. For purposes of determining benefits under this section, "hours of treatment" means treatment rendered on an individual or single-family basis. If treatment is rendered on a group basis, the hours of covered group treatment must be provided at a ratio of no less than two group treatment sessions to one individual treatment hour.

Sec. 16. Minnesota Statutes 1988, section 62A.152, subdivision 3, is amended to read:

Subd. 3. **PROVIDER DISCRIMINATION PROHIBITED.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a licensed psychologist or a licensed consulting psychologist to the extent that the services and treatment are within the scope of licensed psychologist or licensed consulting psychologist licensure. The order of the physician requesting the services of the licensed psychologist or licensed consulting psychologist may be required to be submitted with the claim for payment.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed psychologist or a licensed consulting psychologist in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

Sec. 17. Minnesota Statutes 1988, section 62A.17, subdivision 2, is amended to read:

Subd. 2. **RESPONSIBILITY OF EMPLOYEE.** Every covered employee electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued coverage. If the policy, contract, or health care plan is administered by a trust, every covered employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff

has occurred, without regard to whether such cost is paid by the employer or employee. The employee shall be eligible to continue the coverage until the employee becomes covered under another group health plan, or for a period of 18 months after the termination of or lay off from employment, whichever is shorter. If the employee becomes covered under another group policy, contract, or health plan and the new group policy, contract, or health plan contains any preexisting condition limitations, the employee may, subject to the 18-month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied. The new policy, contract, or health plan is primary except as to the preexisting condition. In the case of a newborn child who is a dependent of the employee, the new policy, contract, or health plan is primary upon the date of birth of the child, regardless of which policy, contract, or health plan coverage is deemed primary for the mother of the child.

Sec. 18. Minnesota Statutes 1988, section 62A.46, is amended by adding a subdivision to read:

Subd. 12. **HOMEBOUND OR HOUSE CONFINED.** "Homebound or house confined" means that a person is physically unable to leave the home without another person's aid because the person has lost the capacity of independent transportation or is disoriented.

Sec. 19. Minnesota Statutes 1988, section 62A.48, subdivision 1, is amended to read:

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover medically prescribed long-term care in nursing facilities and at least the medically prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least $100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums~~, and a requirement of prior hospitalization for up to one day may be imposed only for long-term care in a nursing facility~~. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least $50,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums~~, and a requirement of prior hospitalization for up to three days may be imposed for long-term care in a nursing facility or home care services. If long-term care policies require the policyholder to be admitted to a nursing facility or begin home care services within a specified period after discharge from a hospital, that period may be no less than 30 days~~. Prior hospitalization may not be required under a long-term care policy.

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

Coverage under either policy designation must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under either policy designation may include a waiting period of up to 90 days before benefits are paid, but there must be no more than one waiting period per benefit period. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to ~~meet a prior hospitalization test more than once during a single benefit period~~ be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

Sec. 20. **[62A.60] RETROACTIVE DENIAL OF EXPENSES.**

In cases where the subscriber or insured is liable for costs beyond applicable copayments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.

Sec. 21. Minnesota Statutes 1988, section 62B.01, is amended to read:

62B.01 **SCOPE.**

All life insurance and accident and health insurance in connection with loan or other credit transactions shall be subject to the provisions of sections 62B.01 to 62B.14, except ~~insurance in connection with a loan or other credit transaction of more than five years duration~~ mortgage life, mortgage accidental death, and mortgage disability insurance. Insurance shall not be subject to the provisions of sections 62B.01 to 62B.14 where its issuance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor. Credit life and accident and health insurance provided at no additional cost to the borrower shall not be subject to the provisions of sections 62B.01 to 62B.14.

Sec. 22. Minnesota Statutes 1988, section 62B.04, subdivision 1, is amended to read:

Subdivision 1. **CREDIT LIFE INSURANCE.** (1) The initial amount of credit life insurance shall not exceed the ~~total~~ amount of principal repayable under the contract of indebtedness. Thereafter, if the indebtedness is repayable in substantially equal installments according to a predetermined schedule, the amount of insurance shall not exceed the scheduled or actual amount of indebtedness, whichever is greater.

(2) Notwithstanding clause (1), the amount of credit life insurance written in connection with credit transactions repayable over a specified term exceeding 63 months shall not exceed: (i) the actual amount of unpaid indebtedness as it exists from time to time; or (ii) where an indebtedness is repayable in substantially equal installments according to a predetermined schedule, the scheduled amount of unpaid indebtedness, less any unearned interest or finance charges, plus an amount equal to two monthly payments.

(3) Notwithstanding ~~clause~~ clauses (1) and (2), insurance on educational, agricultural and horticultural credit transaction commitments may be written on a nondecreasing or level term plan for the amount of the loan commitment.

Sec. 23. Minnesota Statutes 1988, section 62D.12, is amended by adding a subdivision to read:

Subd. 1a. **SWING-OUT PRODUCTS.** Notwithstanding subdivision 1, nothing in sections 10, 20, and 27 applies to a commercial health policy issued under this chapter as a companion to a health maintenance contract.

Sec. 24. Minnesota Statutes 1988, section 62E.06, subdivision 1, is amended to read:

Subdivision 1. **NUMBER THREE PLAN.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $500,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $500,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarially equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) hospital services;

(2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a physician or at the physician's direction;

(3) drugs requiring a physician's prescription;

(4) services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;

(5) services of a home health agency if the services would qualify as reimbursable services under Medicare;

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

(9) prostheses other than dental but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;

(10) rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(11) diagnostic X-rays and laboratory tests;

(12) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) services of a physical therapist;

(14) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment; and

(15) services of an occupational therapist.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program except as otherwise provided by ~~law~~ section 62A.04, subdivision 3, clause (4);

(2) any charge for treatment for cosmetic purposes other than for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician;

(3) care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medicare;

(4) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be 90 percent of its lowest private room charge;

(5) that part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory, and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

(f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary treatment for phenylketonuria when recommended by a physician.

(g) Outpatient mental health coverage is subject to section 62A.152, subdivision 2.

Sec. 25. **[65A.061] CREDITORS LIMITED TO EXISTING INSURANCE.**

When a creditor requires a debtor to provide insurance on real or personal property security against reasonable risks of loss, damage, or destruction, no insurance shall be sold or placed by or through the creditor if the debtor provides the creditor with a loss payable through existing policies of insurance that

the debtor owns or controls. This section does not apply if the existing insurance is in an amount less than the amount of indebtedness to be secured on the real or personal property.

This section does not prevent the disapproval of the insurer or a policy of insurance where there are reasonable grounds for believing that the insurer is insolvent or that the insurance is unsatisfactory as to placement with an unauthorized insurer, adequacy of the coverage, adequacy of the insurer to assume the risk to be insured, the assessment features to which the policy is subject, or other grounds that are based on the nature of the coverage and that are not arbitrary, unreasonable or discriminatory. This section does not prevent a mortgage lender or mortgage servicer from requiring that a policy of insurance or renewal of the policy be in conformance with standards of the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation, nor does this section forbid the securing of a policy of insurance or a renewal of the policy at the request of the borrower or because of the borrower's failure to furnish the necessary insurance or renewal.

This section supersedes any inconsistent provision of law to the contrary.

Sec. 26. Minnesota Statutes 1988, section 65B.525, subdivision 1, is amended to read:

Subdivision 1. Except as otherwise provided in section 72A.327, the supreme court and the several courts of general trial jurisdiction of this state shall by rules of court or other constitutionally allowable device, provide for the mandatory submission to arbitration of all cases at issue where the claim at the commencement of arbitration is in an amount of $5,000 or less against any insured's reparation obligor for no-fault benefits or comprehensive or collision damage coverage.

Sec. 27. Minnesota Statutes 1988, section 72A.20, is amended by adding a subdivision to read:

Subd. 4a. **STANDARDS FOR PREAUTHORIZATION APPROVAL.** If a policy of accident and sickness insurance or a subscriber contract requires preauthorization approval for any nonemergency services or benefits, the decision to approve or disapprove the requested services or benefits must be communicated to the insured or the insured's health care provider within ten business days of the preauthorization request provided that all information reasonably necessary to make a decision on the request has been made available to the insurer.

Sec. 28. Minnesota Statutes 1988, 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.

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.

If the commissioner requests copies of contracts with a provider under this clause 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. 29. Minnesota Statutes 1988, section 72A.20, is amended by adding a subdivision to read:

Subd. 24. **CANCELLATIONS AND NONRENEWALS.** No insurer shall cancel or fail to renew an individual life or individual health policy or an individual nonprofit health service plan subscriber contract for nonpayment of

premium unless it mails or delivers to the named insured, at the address shown on the policy or subscriber contract at least 30 days before lapse, final notice of the cancellation or nonrenewal and the effective date of the cancellation or nonrenewal.

If the named insured is not the policy or subscriber contract owner, the notice required by this subdivision must be sent to the insured's last known address, if any, and to the owner's last known address.

Proof of mailing of the notice of lapse for failure to pay the premium before the expiration of the grace period is sufficient proof that notice required in this subdivision has been given.

This subdivision does not apply to a life or health insurance policy or contract upon which premiums are paid at a monthly interval or less and that contains any grace period required by statute for the payment of premiums during which time the insurance continues in force.

Sec. 30. Minnesota Statutes 1988, section 72A.20, is amended by adding a subdivision to read:

Subd. 25. **USE OF STATEMENTS OF A MINOR.** No statement of a minor or information obtained by an insurer or a representative of an insurer from a minor may be used in any manner in regard to a claim unless the parent or guardian of the minor has granted permission for the minor to be interviewed or the minor's statement to be taken.

Sec. 31. Minnesota Statutes 1988, section 72A.20, is amended by adding a subdivision 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. 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 does not apply to individual life and health insurance policies or personal automobile or homeowner's insurance policies.

Sec. 32. Minnesota Statutes 1988, section 72A.20, is amended by adding a subdivision to read:

Subd. 27. **SOLICITATIONS AND SALES OF INSURANCE PRODUCTS TO BORROWERS.** (a) A loan officer, a loan representative, or other person involved in taking or processing a loan may not solicit an insurance product, except for credit life and disability or mortgage life, mortgage accidental death, or mortgage disability, and except for life insurance when offered in lieu of credit life insurance, from the completion of the initial loan application, as defined in the federal Equal Credit Opportunity Act, United States Code, title 15, sections 1691 to 1691f, and any regulations adopted under those sections, until after the closing of the loan transaction.

(b) This subdivision applies only to loan transactions covered by the federal Truth-in-Lending Act, United States Code, title 15, sections 1601 to 1666j, and any regulations adopted under those sections.

(c) This subdivision does not apply to sales of title insurance, homeowner's insurance, a package homeowner's-automobile insurance product, automobile insurance, or a similar insurance product, required to perfect title to, or protect, property for which a security interest will be taken if the product is required as a condition of the loan.

(d) Nothing in this subdivision prohibits the solicitation or sale of any insurance product by means of mass communication.

Sec. 33. **[72A.205] PROHIBITED PROVISIONS AND COVERAGES.**

No policy of insurance paying a death benefit that returns premiums or premiums plus interest, or multiples of less than four times the premiums or premiums plus interest, in lieu of benefits may be issued in this state. This section does not prohibit the return of premiums or premiums plus interest in connection with a voluntary or judicially ordered rescission of the policy, nor in accordance with the terms of exclusions from coverage for suicides, aviation, or war risk.

Sec. 34. **[72A.327] HEALTH CLAIMS; RIGHTS OF APPEAL.**

(a) An insured whose claim for medical benefits under chapter 65B is denied because the treatment or services for which the claim is made is claimed to be experimental, investigative, not medically necessary, or otherwise not generally accepted by licensed health care providers and for which the insured has financial responsibility in excess of applicable copayments and deductibles may appeal the denial to the commissioner.

(b) This section does not apply to claims for health benefits which have been arbitrated under section 65B.525, subdivision 1.

(c) A three-member panel shall review the denial of the claim and report to the commissioner. The commissioner shall establish a list of qualified individuals who are eligible to serve on the panel. In establishing the list, the commissioner shall consult with representatives of the contributing members as defined in section 65B.01, subdivision 2, and professional societies. Each panel must include: one person with medical expertise as identified by the contributing members; one person with medical expertise as identified by the professional societies; and one public member. The commissioner, upon initiation of an

arbitration, shall select from each list three potential arbitrators and shall notify the issuer and the claimant of the selection. Each party shall strike one of the potential arbitrators and an arbitrator shall be selected by the commissioner from the remaining names of potential arbitrators if more than one potential arbitrator is left. In the event of multiparty arbitration, the commissioner may increase the number of potential arbitrators and divide the strikes so as to afford an equal number of strikes to each adverse interest. If the selected arbitrator is unable or unwilling to serve for any reason, the commissioner may appoint an arbitrator, which will be subject to challenge only for cause. The party that denied the coverage has the burden of proving that the services or treatment are experimental, investigative, not medically necessary, or not generally accepted by licensed health care professionals. In determining whether the burden has been met, the panel may consider expert testimony, medical literature, and any other relevant sources. If the party fails to sustain its burden, the commissioner may order the immediate payment of the claim. All proceedings of the panel and any documents received or developed by the review process are nonpublic.

(d) A person aggrieved by an order under this section may appeal the order. The appeal shall be pursuant to section 65B.525 where appropriate, or to the district court for a trial de novo, in all other cases. In nonemergency situations, if the insurer has an internal grievance or appeal process, the insured must exhaust that process before the external appeal. In no event shall the internal grievance process exceed the time limits described in section 72A.201, subdivision 4a.

(e) If prior authorization is required before services or treatment can be rendered, an appeal of the denial of prior authorization may be made as provided in this section.

(f) The commissioner shall adopt procedural rules for the conduct of appeals.

(g) The permanent rulemaking authority granted in this section is effective the day following final enactment of the section regardless of the actual effective date of the section.

Sec. 35. Minnesota Statutes 1988, section 149.11, is amended to read:

149.11 **PREARRANGED FUNERAL PLANS; CONTRACTS; TRUST FUNDS.**

(a) When prior to the death of any person, that person or another enters into any transaction, makes a contract, or any series or combination of transactions or contracts with another person, partnership, association or corporation, other than an insurance company licensed to do business in the state of Minnesota, by the terms of which, certain personal property related to the funeral services or the burial, cremation, or other disposition of human remains will be used upon the death of the person for whom the property is to be used, or when the professional services of a funeral director or embalmer will then be furnished, or both, then the total of all money paid by the terms of the transaction,

contract or series or combination of transactions or contracts shall be held in trust for the purpose for which it has been paid until the death of the person for whose benefit the money was paid, or refunded to the person who made the payment or payments, upon demand. A prearranged funeral or burial contract buyer may, at the buyer's option, declare the funeral or burial trust to be irrevocable up to an amount equivalent to the current allowable supplemental security income asset exclusion used for determining eligibility for public assistance. The contract buyer may, at the buyer's option, also declare the interest to be irrevocable to the extent permitted by federal laws and rules governing public assistance. The buyer of either a revocable or an irrevocable prearranged funeral or burial contract retains the right to designate as trustee a different funeral establishment at any time before the death of the person for whose benefit the money was paid. Upon the death of that person, the next of kin or other legal representative of that person's estate retains the right to designate as trustee a different funeral establishment. Accruals of interest or dividends declared upon the sum of money held in trust are subject to the same trust. The person, partnership, association or corporation holding the money in trust shall inform the person on whose behalf the money is held that all money paid plus all accrued earnings will be held in trust until the death of that person or until a request for a refund is made if made prior to death, except for a prearranged funeral or burial trust declared irrevocable by the buyer under this section. The location of the trust account including the name and address of the institution in which the money is being held and any identifying account numbers, and any subsequent changes in that information must be disclosed in writing to the person on whose behalf the money is being held, at the time the funds are deposited into the trust account and at the time of any subsequent changes in the information. The personal property shall include but not be limited to a casket, burial vault not interred in a grave, combination casket-vault or other receptacle not described in paragraph (b) for the internment, entombment, cremation, or other disposition of human remains.

(b) Nothing in this section shall prevent the sale and delivery of cemetery lots, graves, burial vaults preinterred in a grave, cremation urns, crypt spaces, niches, or grave or lot markers or monuments before their use is required. Nothing in this section prevents the preconstruction sale of crypt spaces to be permanently installed except that any seller of mausoleum space or columbarium space, selling burial space in a mausoleum or columbarium that is not completely constructed and usable, must comply with section 306.90.

(c) It is the intent of the legislature that the provisions of this section shall be construed as a limitation upon the manner in which a person or legal entity is permitted to accept funds in prepayment of funeral services to be performed in the future or in prepayment of funeral or burial goods to be used in connection with the funeral or final disposition of human remains. It is further intended to allow members of the public to arrange and pay for funerals, final dispositions, funeral services, and funeral and burial goods for themselves and their families in advance of need while at the same time providing all possible safeguards so that the prepaid funds cannot be dissipated, whether intentionally or not, so as to be available for the payment of the services and goods selected.

Sec. 36. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall, as part of the regular process of statutory revision, prepare a bill for introduction that amends Minnesota Statutes to reflect the intent of the legislature as expressed in section 3 to make uniform the service of process provisions in Minnesota Statutes, chapters 45 to 83, 155A, 309, and 332.

Sec. 37. **REPEALER.**

Minnesota Statutes 1988, sections 60A.23, subdivision 7; and 72A.13, subdivision 2, are repealed.

Sec. 38. **EFFECTIVE DATE.**

Sections 1 to 3, 5, 6, 8, 9, 11 to 14, 18, 23 to 25, 28, 30, 32, 33, 36, and 37 are effective the day following final enactment. Sections 4, 7, 10, 17, 20, 27, 29, 31, and 35 are effective August 1, 1989. Sections 15, 16, 19, 21, and 22 are effective for policies, plans, or contracts issued or renewed on or after August 1, 1989.

Sections 26 and 34 are effective January 1, 1990.

Presented to the governor May 30, 1989

Signed by the governor June 1, 1989, 11:52 p.m.

CHAPTER 331—H.F.No. 333

An act relating to recreational vehicles; regulating all-terrain vehicles, snowmobiles, and motorized bicycles; setting fees; revising liability provisions regarding county administered lands, recreational areas and the Minnesota zoological garden; requiring evaluation and recommendations to the legislature concerning family use of all-terrain vehicles; imposing a penalty; amending Minnesota Statutes 1988, sections 3.736, subdivision 3; 84.87, subdivision 1; 84.92, subdivision 1, and by adding subdivisions; 84.922, subdivisions 1 and 5, and by adding subdivisions; 84.924, subdivision 3; 84.9256, subdivisions 1, 2, and 3; 84.928, subdivisions 1, 2, and 6; 84.929; 169.02, subdivision 1; 169.223; 171.03; and 466.03, by adding a subdivision; repealing Minnesota Statutes 1988, sections 84.922, subdivision 8; 84.925, subdivision 2; and 84.928, subdivision 7.

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

Section 1. Minnesota Statutes 1988, section 3.736, subdivision 3, is amended to read:

Subd. 3. **EXCLUSIONS.** Without intent to preclude the courts from finding additional cases where the state and its employees should not, in equity and