CHAPTER 72A

REGULATION OF TRADE PRACTICES

72A.13 ACCIDENT AND HEALTH INSURANCE, VIOLATIONS OF CERTAIN SECTIONS; PENALTIES.

[For text of subd 1, see M.S.1988]

Subd. 2. [Repealed, 1989 c 330 s 37]

[For text of subd 3, see M.S.1988]

72A.20 METHODS, ACTS AND PRACTICES WHICH ARE DEFINED AS UNFAIR OR DECEPTIVE.

[For text of subds 1 to 4, see M.S.1988]

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.

[For text of subds 5 to 10, see M.S.1988]

Subd. 11. **Application to certain sections.** Violating any provision of the following sections of this chapter not set forth in this section shall constitute an unfair method of competition and an unfair and deceptive act or practice: sections 72A.12, subdivisions 2, 3, and 4, 72A.16, subdivision 2, 72A.03 and 72A.04, 72A.08, subdivision 1, as modified by sections 72A.08, subdivision 4, 72A.201, sections 72A.49 to 72A.505, and 65B.13.

[For text of subds 12 to 14, see M.S.1988]

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.

[For text of subd 16, see M.S.1988]

Subd. 17. **Return of premiums.** (a) Refusing, upon surrender of an individual policy of life insurance in the case of the insured's death, or in the case of a surrender prior to death, of an individual insurance policy not covered by the standard nonforfeiture laws under section 61A.24, to refund to the owner all unearned premiums paid on the policy covering the insured as of the time of the insured's death or surrender if the unearned premium is for a period of more than one month.

(b) Refusing, upon termination or cancellation of a policy of automobile insurance under section 65B.14, subdivision 2, or a policy of homeowner's insurance under section 65A.27, subdivision 4, or a policy of accident and sickness insurance under section 62A.01, or a policy of comprehensive health insurance under chapter 62E, to refund to the insured all unearned premiums paid on the policy covering the insured as of the time of the termination or cancellation if the unearned premium is for a period of more than one month.

(c) This subdivision does not apply to policies of insurance providing coverage only for motorcycles or other seasonally rated or limited use vehicles where the rate is reduced to reflect seasonal or limited use.

(d) For purposes of this section, a premium is unearned during the period of time the insurer has not been exposed to any risk of loss. Except for premiums for motorcycle coverage or other seasonally rated or limited use vehicles where the rate is reduced to reflect seasonal or limited use, the unearned premium is determined by multiplying the premium by the fraction that results from dividing the period of time from the date of termination to the date the next scheduled premium is due by the period of time for which the premium was paid.

(e) The owner may cancel a policy referred to in this section at any time during the policy period. This provision supersedes any inconsistent provision of law or any inconsistent policy provision.

[For text of subds 18 and 19, see M.S.1988]

Subd. 20. **Contact with department.** An insurance company may not terminate or otherwise penalize an insurance agent solely because the agent contacted any government department or agency regarding a problem that the agent or an insured may be having with an insurance company.

Subd. 21. No insurance company doing business in this state shall engage in any selection or underwriting practice that is arbitrary, capricious, or unfairly discriminatory.

Subd. 22. **Limitations on health care providers.** (a) No insurer providing benefits under the Minnesota no-fault automobile insurance act or a plan authorized by sections 471.617 or 471.98 to 471.982 may limit the type of licensed health care provider who may provide treatment for covered conditions under a policy so long as the services provided are within the scope of licensure for the provider. The insurer may not exclude a specific method of treatment for a covered condition if that exclusion has the effect of excluding a specific type of licensed health care provider from treating a covered condition.

(b) This subdivision does not limit the right of an insurer to contract with individual members of any type of licensed health care provider to the exclusion of other members of the group, nor shall it limit the right to the insurer to exclude coverage for a type of treatment if the insurer can show the treatment is not medically necessary or is not medically appropriate.

Subd. 23. **Discrimination in automobile insurance policies.** (a) No insurer that offers an automobile insurance policy in this state shall:

(1) use the employment status of the applicant as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

(b) No insurer that offers an automobile insurance policy in this state shall:

(1) use the applicant's status as a tenant, as the term is defined in section 566.18, subdivision 2, as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

(c) No insurer that offers an automobile insurance policy in this state shall:

(1) use the failure of the applicant to have an automobile policy in force during any period of time before the application is made as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

This provision does not apply if the applicant was required by law to maintain automobile insurance coverage and failed to do so.

An insurer may require reasonable proof that the applicant did not fail to maintain this coverage. The insurer is not required to accept the mere lack of a conviction or citation for failure to maintain this coverage as proof of failure to maintain coverage.

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.

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.

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.

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.

History: *1989 c 170 s 3; 1989 c 260 s 17-20; 1989 c 316 s 1; 1989 c 330 s 27-32*

72A.201 REGULATION OF CLAIMS PRACTICES.

[For text of subds 1 to 4, see M.S.1988]

Subd. 5. **Standards for fair settlement offers and agreements.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) making any partial or final payment, settlement, or offer of settlement, which does not include an explanation of what the payment, settlement, or offer of settlement is for;

(2) making an offer to an insured of partial or total settlement of one part of a claim contingent upon agreement to settle another part of the claim;

(3) refusing to pay one or more elements of a claim by an insured for which there is no good faith dispute;

(4) threatening cancellation, rescission, or nonrenewal of a policy as an inducement to settlement of a claim;

(5) notwithstanding any inconsistent provision of section 65A.01, subdivision 3, failing to issue payment for any amount finally agreed upon in settlement of all or part of any claim within five business days from the receipt of the agreement by the insurer or from the date of the performance by the claimant of any conditions set by such agreement, whichever is later;

(6) failing to inform the insured of the policy provision or provisions under which payment is made;

(7) settling or attempting to settle a claim or part of a claim with an insured under actual cash value provisions for less than the value of the property immediately preceding the loss, including all applicable taxes and license fees. In no case may an insurer be required to pay an amount greater than the amount of insurance;

(8) except where limited by policy provisions, settling or offering to settle a claim or part of a claim with an insured under replacement value provisions for less than the sum necessary to replace the damaged item with one of like kind and quality, including all applicable taxes, license, and transfer fees;

(9) reducing or attempting to reduce for depreciation any settlement or any offer of settlement for items not adversely affected by age, use, or obsolescence;

(10) reducing or attempting to reduce for betterment any settlement or any offer of settlement unless the resale value of the item has increased over the preloss value by the repair of the damage.

Subd. 6. **Standards for automobile insurance claims handling, settlement offers, and agreements.** In addition to the acts specified in subdivisions 4, 5, 7, 8, and 9, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) if an automobile insurance policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) comparable and available replacement automobile, with all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to the transfer or evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy;

(b) a cash settlement based upon the actual cost of purchase of a comparable automobile, including all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. The costs must be determined by:

(i) the cost of a comparable automobile, adjusted for mileage, condition, and options, in the local market area of the insured, if such an automobile is available in that area; or

(ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable automobile is not available in the local market area. The insured shall be provided the information contained in all quotations prior to settlement; or

(iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the insured;

(2) if an automobile insurance policy provides for the adjustment and settlement of an automobile partial loss on the basis of repair or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) to assume all costs, including reasonable towing costs, for the satisfactory

repair of the motor vehicle. Satisfactory repair includes repair of both obvious and hidden damage as caused by the claim incident. This assumption of cost may be reduced by applicable policy provision; or

(b) to offer a cash settlement sufficient to pay for satisfactory repair of the vehicle. Satisfactory repair includes repair of obvious and hidden damage caused by the claim incident, and includes reasonable towing costs;

(3) regardless of whether the loss was total or partial, in the event that a damaged vehicle of an insured cannot be safely driven, failing to exercise the right to inspect automobile damage prior to repair within five business days following receipt of notification of claim. In other cases the inspection must be made in 15 days;

(4) regardless of whether the loss was total or partial, requiring unreasonable travel of a claimant or insured to inspect a replacement automobile, to obtain a repair estimate, to allow an insurer to inspect a repair estimate, to allow an insurer to inspect repairs made pursuant to policy requirements, or to have the automobile repaired;

(5) regardless of whether the loss was total or partial, if loss of use coverage exists under the insurance policy, failing to notify an insured at the time of the insurer's acknowledgment of claim, or sooner if inquiry is made, of the fact of the coverage, including the policy terms and conditions affecting the coverage and the manner in which the insured can apply for this coverage;

(6) regardless of whether the loss was total or partial, failing to include the insured's deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered by the insured, except that when an insurer is recovering directly from an uninsured third party by means of installments, the insured must receive the full deductible share as soon as that amount is collected and before any part of the total recovery is applied to any other use. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney;

(7) requiring as a condition of payment of a claim that repairs to any damaged vehicle must be made by a particular contractor or repair shop or that parts, other than window glass, must be replaced with parts other than original equipment parts;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that the claimant may have a claim for loss of use of the vehicle;

(9) failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability;

(10) failing to pay any interest required by statute on overdue payment for an automobile personal injury protection claim;

(11) if an automobile insurance policy contains either or both of the time limitation provisions as permitted by section 65B.55, subdivisions 1 and 2, failing to notify the insured in writing of those limitations at least 60 days prior to the expiration of that time limitation;

(12) if an insurer chooses to have an insured examined as permitted by section 65B.56, subdivision 1, failing to notify the insured of all of the insured's rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination.

[For text of subds 7 to 10, see M.S.1988]

Subd. 11. **Disclosure mandatory.** An insurer must disclose the coverage and limits of an insurance policy within 30 days after the information is requested in writing by a claimant.

Subd. 12. **Prejudgment interest.** If a judgment is entered against an insured, the principal amount of which is within the applicable policy limits, the insurer is responsible for their insured's share of the costs, disbursements, and prejudgment interest, as

determined under section 549.09, included in the judgment even if the total amount of the judgment is in excess of the applicable policy limits.

History: *1989 c 193 s 1; 1989 c 260 s 21-23*

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.

History: *1989 c 330 s 33*

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 June 2, 1989, regardless of the actual effective date of January 1, 1990.

History: *1989 c 330 s 34*

72A.49 SHORT TITLE.

Sections 72A.49 to 72A.505 may be cited as the "Minnesota insurance fair information reporting act."

History: *1989 c 316 s 2*

72A.491 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 72A.49 to 72A.505, the following terms have the meanings given them.

Subd. 2. **Adverse underwriting decision.** "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(1) denial, in whole or in part, of coverage that was requested in writing to the insurer;

(2) termination or reduction of insurance coverage or policy;

(3) failure of an insurance agent to apply for coverage with a specific insurer that the agent represents and that is specifically requested by an applicant;

(4) placement by an insurer or insurance agent of a risk with a residual market mechanism, an unauthorized insurer, or an insurer that specializes in substandard risks;

(5) charging a higher rate on the basis of information that differs from that which the applicant or policyholder furnished for property or casualty coverage;

(6) an offer to insure at higher than standard rates for life, health, or disability coverage; or

(7) the rescission of a policy.

Subd. 3. **Affiliate or affiliated.** "Affiliate" or "affiliated" means a person who directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

Subd. 4. **Applicant.** "Applicant" means any person who seeks to contract for insurance coverage from an insurer.

Subd. 5. **Consumer report.** "Consumer report" means any written, oral, or other communication of information bearing on a person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used in connection with an insurance transaction.

Subd. 6. **Consumer reporting agency.** "Consumer reporting agency" means any person who:

(1) regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

(2) obtains information primarily from sources other than insurers; and

(3) furnishes consumer reports to other persons.

Subd. 7. **Control.** "Control," "controlled by," or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

Subd. 8. **Health care institution.** "Health care institution" means any facility or institution that is licensed to provide health care services to natural persons.

Subd. 9. **Health professional.** "Health professional" means any person licensed or certified to provide health care services to natural persons.

Subd. 10. **Health record information.** "Health record information" means personal information that:

(1) relates to an individual's physical or mental condition, health history, or health treatment; and

(2) is obtained from a health professional or health care institution, from the individual, or from the individual's spouse, parent, legal guardian, or other person.

Subd. 11. **Individual.** "Individual" means any natural person who:

(1) in the case of property or casualty insurance is a past, present, or proposed named insured or certificate holder;

(2) in the case of life, health, or disability insurance is a past, present, or proposed principal insured or certificate holder;

(3) is a past, present, or proposed policy owner;

(4) is a past or present applicant;

(5) is a past or present claimant; or

(6) derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this act.

Subd. 12. **Insurance-support organization.** (a) "Insurance-support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about persons for the primary purpose of providing the information to an insurer or insurance agent for insurance transactions, including:

(1) the furnishing of consumer reports or investigative consumer reports to an insurer or insurance agent for use in connection with an insurance transaction; and

(2) the collection of personal information from insurers, insurance agents, or other insurance-support organizations to detect or prevent fraud, material misrepresentation, or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(b) Insurance-support organizations do not include insurance agents, government institutions, insurers, health care institutions, or health professionals.

Subd. 13. **Insurance transaction.** "Insurance transaction" means any transaction that involves:

(1) the determination of an individual's eligibility for an insurance coverage, benefit, or payment; or

(2) the servicing of an insurance application, policy, contract, or certificate.

Subd. 14. **Insurer.** "Insurer" means any insurance company, risk retention group as defined under section 60E.02, service plan corporation as defined under section 62C.02, health maintenance organization as defined under section 62D.02, fraternal benefit society regulated under chapter 64B, township mutual company regulated under chapter 67A, joint self-insurance plan or multiple employer trust regulated under chapter 60F, 62H, or section 471.617, subdivision 2, and persons administering a self-insurance plan as defined under section 60A.23, subdivision 8, paragraph (2), clauses (a) and (d).

Subd. 15. **Insurer that specializes in substandard risks.** "Insurer that specializes in substandard risks" means an insurer whose rates and market orientation are directed at risks other than preferred or standard risks.

Subd. 16. **Investigative consumer report.** "Investigative consumer report" means all or part of a consumer report in which information about a person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning these items of information.

Subd. 17. **Personal information.** "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. The term includes the individual's name and address and health record information, but does not include privileged information. Personal information does not include health information maintained by a health maintenance organization as defined under section 62D.02, subdivision 4, in its capacity as a health provider.

Subd. 18. **Policyholder.** "Policyholder" means any individual who is a present named insured, a present policyowner, or a present group certificate holder.

Subd. 19. **Privileged information.** (a) "Privileged information" means any individually identifiable information that:

(1) relates to a claim for insurance benefits or a civil or criminal proceeding; or

(2) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding.

(b) Information otherwise meeting the definition of privileged information under paragraph (a) must be considered personal information if it is disclosed in violation of section 72A.502.

Subd. 20. **Residual market mechanism.** "Residual market mechanism" means an association, organization, or other entity created under the laws of this state to provide insurance coverage to any person who is unable to obtain coverage through ordinary methods in the normal insurance markets.

Subd. 21. **Termination of insurance coverage or policy.** "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

Subd. 22. **Unauthorized insurer.** "Unauthorized insurer" means an insurance company that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state.

History: *1989 c 316 s 3*

72A.492 SCOPE.

Subdivision 1. **Covered policies.** The obligations imposed by sections 72A.49 to 72A.505 apply to insurers, insurance agents, and insurance-support organizations that:

(1) collect, receive, or maintain information in connection with insurance transactions that pertains to persons who are residents of this state; or

(2) engage in insurance transactions with applicants, individuals, or policyholders who are residents of this state.

Subd. 2. **Covered persons.** The rights granted by sections 72A.49 to 72A.505 extend to:

(1) a person who is a resident of this state and is the subject of information collected, received, or maintained in connection with an insurance transaction; and

(2) a person who is a resident of this state and engages in or seeks to engage in an insurance transaction.

Subd. 3. **Exceptions.** (a) Sections 72A.49 to 72A.505 do not apply to information collected from the public records of a governmental authority and maintained by an insurance company or its representatives to insure the title to real property located in this state.

(b) Nothing in sections 72A.49 to 72A.505 gives a patient access to the health records pertaining to the patient maintained by the patient's health provider, or gives the patient the right to alter or amend those health records, unless otherwise provided by law.

(c) Sections 72A.49 to 72A.505 do not apply to any insurance transactions involving property and casualty insurance primarily for business or professional needs.

History: *1989 c 316 s 4*

72A.493 OBTAINING INFORMATION BY IMPROPER MEANS.

An insurer, insurance agent, or insurance-support organization must not obtain information or authorize another person to obtain information in connection with an insurance transaction by:

(1) pretending to be someone he or she is not;

(2) pretending to represent a person he or she is not in fact representing;

(3) misrepresenting the true purpose of the interview; or

(4) refusing to identify himself or herself upon request.

History: *1989 c 316 s 5*

72A.494 NOTICE.

Subdivision 1. **Required.** Each insurer or insurance agent shall provide a notice relating to information practices to each applicant or policyholder in the manner and at the time required by this section.

Subd. 2. **Exemption.** A notice is not required to be provided under this section for:

(1) a group policy or contract that is not individually underwritten; or

(2) a renewal, reinstatement, or a change in benefits for a policy or contract if no personal information is to be collected other than from the applicant or policyholder, or from public records.

Subd. 3. **Timing.** (a) In the case of an application for insurance coverage, the notice must be provided to the applicant or policyholder no later than the time application is made for the coverage, renewal, reinstatement, or change in benefits.

(b) If personal information is to be collected only from the applicant or from public records, the notice may be provided at the time of delivery of the policy or the certificate.

Subd. 4. **Content of notice.** The notice required by this section must be in writing and state:

(1) whether personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) the types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect the information;

(3) the types of disclosures of personal information that may be made under section 72A.501 and the circumstances under which the disclosures may be made without prior authorization; except that only those circumstances which occur with such frequency as to indicate a general business practice must be described;

(4) a description of the rights established under sections 72A.497 and 72A.498 and the manner in which those rights may be exercised; and

(5) that information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

Subd. 5. **Abbreviated notice.** In lieu of the notice required under subdivision 4, the insurer or insurance agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) personal information may be collected from persons other than the person or persons proposed for coverage;

(2) the information collected by the insurer or insurance agent may in certain circumstances be disclosed to third parties without authorization;

(3) the person has a right to see their personal records and correct personal information collected; and

(4) the person will be furnished the detailed notice required under subdivision 4 upon request.

Subd. 6. **Other companies or agencies acting on its behalf.** The obligations imposed by this section upon an insurer or insurance agent may be satisfied by another insurer or insurance agent authorized to act on its behalf.

History: *1989 c 316 s 6*

72A.495 MARKETING AND RESEARCH SURVEYS.

An insurer or insurance agent shall clearly specify any questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction, and state that responses to the questions are not required to obtain coverage.

History: *1989 c 316 s 7*

72A.496 INVESTIGATIVE CONSUMER REPORTS.

Subdivision 1. **Notice.** An insurer, insurance agent, or insurance-support organization must not prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement, or a change in insurance benefits, unless the insurer or insurance agent informs the person:

(1) that the individual may request to be interviewed in connection with the preparation of the investigative consumer report; and

(2) that, upon a request pursuant to section 72A.497, the individual is entitled to receive a copy of the investigative consumer report.

Subd. 2. **Reports prepared by insurers.** If an investigative consumer report is to be prepared by an insurer or insurance agent, the insurer or insurance agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

Subd. 3. **Reports prepared by insurance-support organizations.** If an investigative consumer report is to be prepared by an insurance-support organization, the insurer or insurance agent desiring the report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures for conducting an interview, if requested.

History: *1989 c 316 s 8*

72A.497 ACCESS TO PERSONAL INFORMATION.

Subdivision 1. **Request.** (a) If an individual, after proper identification, submits a written request to an insurer, insurance agent, or insurance-support organization for access to personal information about the individual, the insurer, insurance agent, or insurance-support organization shall within 30 business days from the date the request is received:

(1) inform the individual of the nature and substance of the personal information that they possess in writing, by telephone, or by other oral communication, whichever the insurer, insurance agent, or insurance-support organization elects;

(2) permit the individual to see and copy, in person, the personal information pertaining to that person;

(3) permit the individual to obtain by mail a copy of all of the personal information or a reasonably described portion thereof, whichever the individual requests;

(4) disclose to the individual the identity of those persons to whom the insurer, insurance agent, or insurance-support organization has disclosed the personal information within two years before the request; and

(5) provide the individual with a summary of the procedures by which the person may request correction, amendment, or deletion of personal information, as provided under section 72A.498.

(b) If the personal information is in coded form, an accurate translation in plain language must be provided in writing.

(c) If credit information is requested that federal law prohibits an insurer to disclose, the insurer must disclose that the individual has the right to receive the credit information from the credit reporting agency. The insurer must disclose the name, address, and telephone number of the credit reporting agency that supplied the insurer with the credit information.

Subd. 2. **Source.** Any personal information collected must specifically identify the source of the information.

Subd. 3. **Health records.** (a) Health record information requested under subdivision 1 that has been supplied by a health care institution or a health professional must provide the identity of the health professional or health care institution that supplied the information. The health record information must be provided either directly to the individual or to a health professional designated by the person who is licensed to provide health care with respect to the condition to which the information relates, whichever the individual elects. If the information is provided to a designated health professional, the insurer, insurance agent, or insurance-support organization shall notify the person, at the time of the disclosure, that the information has been provided to the health professional.

(b) If a health professional or a health care institution has provided health information to an insurer, insurance-support organization, or insurance agent that the health professional or health care institution has determined and indicates in writing that the release of the health record information is detrimental to the physical or mental health of the person, or is likely to cause the individual to inflict self-harm or to harm another, the insurer, insurance agent, or insurance-support organization may provide that information directly to the individual only with the approval of the health professional with treatment responsibility for the condition to which the information relates. If approval is not obtained, the information must be provided to the health professional designated by the individual.

(c) Nothing in this section may reduce or affect a patient's rights under section 144.335.

Subd. 4. **Fee.** An insurer, insurance agent, or insurance-support organization may charge a reasonable fee, not to exceed the actual costs, to copy information provided under this section. If an individual is requesting information as a result of an adverse underwriting decision, the insurer, insurance agent, or insurance-support organization must provide the information free of any charge.

Subd. 5. **Other companies or agents acting on its behalf.** The obligations imposed by this section upon an insurer or insurance agent may be satisfied by another insurer or insurance agent authorized to act on its behalf. With respect to the copying and disclosure of personal information under a request under subdivision 1, an insurer, insurance agent, or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose personal information on its behalf.

Subd. 6. **Privileged information.** The rights granted under this section and section 72A.498 do not extend to privileged information.

History: *1989 c 316 s 9*

72A.498 CORRECTION, AMENDMENT, OR DELETION OF PERSONAL INFORMATION.

Subdivision 1. **Procedure.** Within 30 business days from the date of receipt of a written request from an individual to correct, amend, or delete any personal information about the person within its possession, an insurer, insurance agent, or insurance-support organization shall either:

(1) correct, amend, or delete the portion of the personal information in dispute; or

(2) notify the individual of its refusal to make the correction, amendment, or deletion, the reasons for the refusal, and the person's right to file a statement as provided in subdivision 3, and the individual's right to appeal to the commissioner under subdivision 5.

Subd. 2. **Notice.** If the insurer, insurance agent, or insurance-support organization corrects, amends, or deletes disputed personal information upon request of an individual or as ordered by the commissioner, the insurer, insurance agent, or insurance-

support organization shall notify the person in writing and provide the correction, amendment, or fact of deletion to:

(1) any person specifically designated by the individual who may have within the preceding two years received the personal information;

(2) any insurance-support organization whose primary source of personal information is insurers, if the insurance-support organization has systematically received the personal information from the insurer within the preceding seven years, provided that the correction, amendment, or fact of deletion need not be provided to an insurance-support organization if the insurance-support organization no longer maintains personal information about the individual; and

(3) any insurance-support organization that provided the personal information that has been corrected, amended, or deleted.

Subd. 3. **Statement.** If the insurer, insurance agent, or insurance-support organization refuses to correct, amend, or delete disputed personal information, the individual must be permitted to file with the insurer, insurance agent, or insurance-support organization a concise statement setting forth what the person thinks is the correct, relevant, or fair information and stating the reasons why the individual disagrees with the insurer's, insurance agent's, or insurance-support organization's refusal to correct, amend, or delete disputed personal information.

Subd. 4. **Disputed information.** In the event an individual files a statement described in subdivision 3, the insurer, insurance agent, or insurance-support organization shall:

(1) file the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it;

(2) in any subsequent disclosure by the insurer, insurance agent, or insurance-support organization of the disputed personal information, clearly identify the matter or matters in dispute and provide the individual's statement along with the personal information being disclosed; and

(3) furnish the statement to the persons and in the manner specified in subdivision 2.

Subd. 5. **Appeal.** (a) If an insurer, insurance-support organization, or insurance agent refuses to correct, amend, or delete disputed personal information, the individual may file an appeal with the commissioner.

(b) The commissioner may, after providing the insurer, insurance-support organization, or insurance agent an opportunity for a hearing, order the insurer, insurance-support organization, or insurance agent to amend, correct, or delete disputed personal information if the commissioner finds that the personal information kept by the insurer, insurance-support organization, or insurance agent is in error. If the commissioner finds that the disputed personal information maintained by the insurer, insurance agent, or insurance-support organization is correct, the insurer, insurance agent, or insurance-support organization may delete from the individual's records any statement filed with them by that individual relating to the disputed information under subdivision 3.

History: *1989 c 316 s 10*

72A.499 REASONS FOR ADVERSE UNDERWRITING DECISIONS.

Subdivision 1. **Notice and information.** In the event of an adverse underwriting decision, the insurer or insurance agent responsible for the decision shall provide in writing to the applicant, policyholder, or individual proposed for coverage:

(1) the specific reason or reasons for the adverse underwriting decision, a summary of the person's rights under sections 72A.497 and 72A.498, and that upon request the person may receive the specific items of personal information that support those reasons and the specific sources of the information; or

(2) the specific reason or reasons for the adverse underwriting decision, the specific items of personal and privileged information that support those reasons, the names and addresses of the sources that supplied the specific items of information specified, and a summary of the rights established under sections 72A.497 and 72A.498.

Subd. 2. **Health reasons.** If the specific reason for an adverse underwriting decision is based on health record information, the insurer may, in lieu of providing the specific reason to the individual under subdivision 1, provide the individual with the specific source of the adverse underwriting decision referring to the specific date, page, and line of the information received from a health professional or health care institution. If the insured has been informed of the condition indicated by their health provider and is unable to determine the reason for the adverse underwriting decision, then the insurer must provide the specific reason to the individual. The insurer must provide the specific reason for the adverse underwriting decision to a health professional designated by the individual, if requested either orally or in writing by the individual.

Subd. 3. **Exemption.** (a) This section is not applicable to group policies or contracts, except for group policies that are individually underwritten. For group policies or contracts that are individually underwritten, the notice required under this section must be given to the individual or individuals in the group whose personal information resulted in the adverse underwriting decision.

(b) If a policy or contract is terminated on a class or statewide basis, or an insurance coverage is declined solely because the coverage is unavailable on a class or statewide basis, the insurer or agent is not required to provide the notice required under this section provided that the applicant or policyholder is provided with the specific reason for the termination or declination of coverage.

Subd. 4. **Privileged information.** (a) An insurer or insurance agent is not required to provide particular, specific items of privileged information under subdivision 1 if it has a reasonable suspicion, based upon that specific information, that the applicant, policyholder, or person proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure. If an insurer or insurance agent does not provide the specific items of information because the information is privileged under this subdivision, the insurer or insurance agent must notify the applicant, policyholder, or individual proposed for coverage that the specific items of information are privileged and of the person's right to appeal to the commissioner under this subdivision.

(b) If a person is not provided with the specific items of information relating to an adverse underwriting decision because the information is privileged under this subdivision, the person may request that the commissioner review the information. The commissioner may then order the insurer or insurance agent to supply the privileged information to the commissioner. If the commissioner determines that the information is not privileged under this subdivision, the commissioner shall order the insurer or insurance agent to provide the information to the applicant, policyholder, or person proposed for coverage.

Subd. 5. **Health records information.** Specific items of health record information supplied by a health care institution or health professional, and the identity of the health professional or health care institution that supplied the information, must be disclosed in the manner required under section 72A.497, subdivision 3.

Subd. 6. **Other companies or agents acting on their behalf.** The obligations imposed by this section upon an insurer or insurance agent may be satisfied by another insurer or insurance agent authorized to act on its behalf.

History: *1989 c 316 s 11*

72A.50 PREVIOUS ADVERSE UNDERWRITING DECISIONS.

Subdivision 1. **Additional information required.** An insurer, insurance agent, or insurance-support organization must not seek information in connection with an insurance transaction concerning any previous adverse underwriting decision experi-

enced by a person, or any previous insurance coverage obtained by a person through a residual market mechanism, unless the inquiry also requests the reasons for the previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism.

Subd. 2. **Prohibitions.** An insurer or insurance agent may not base an adverse underwriting decision, in whole or in part, on:

(1) the fact of a previous adverse underwriting decision or the fact that a person previously obtained insurance coverage through a residual market mechanism, provided that an insurer or insurance agent may base an adverse underwriting decision on further information obtained from an insurer or insurance agent responsible for a previous adverse underwriting decision; or

(2) personal information received from an insurance-support organization whose primary source of information is insurers, provided that an insurer or insurance agent may base an adverse underwriting decision on further personal information obtained as the result of information received from the insurance-support organization.

History: *1989 c 316 s 12*

72A.501 DISCLOSURE AUTHORIZATION.

Subdivision 1. **Requirement; content.** An authorization used by an insurer, insurance-support organization, or insurance agent to disclose or collect personal information must be in writing and must meet the following requirements:

(1) is written in plain language;

(2) is dated;

(3) specifies the types of persons authorized to disclose information about the person;

(4) specifies the nature of the information authorized to be disclosed;

(5) names the insurer or insurance agent and identifies by generic reference representatives of the insurer to whom the person is authorizing information to be disclosed;

(6) specifies the purposes for which the information is collected; and

(7) specifies the length of time the authorization remains valid.

Subd. 2. **Application.** (a) If the authorization is signed to collect information in connection with an application for a property and casualty insurance policy, a policy reinstatement, or a request for a change in benefits, the authorization must not remain valid for longer than one year from the date the authorization is signed or the date the insurer grants or denies coverage, reinstatement, or change in benefits, whichever is sooner.

(b) If the authorization is signed to collect information in connection with an application for a life, disability, and health insurance policy or contract, reinstatement, or request for change in benefits, the authorization may not remain valid for longer than 26 months from the date the authorization is signed.

Subd. 3. **Claims.** If the authorization is signed to collect information in connection with a claim for benefits under an insurance policy, the authorization must not remain valid for longer than:

(1) the term of coverage of the policy, if the claim is for a health insurance benefit; or

(2) the duration of the claim, if the claim is for a claim other than for a health insurance benefit.

Subd. 4. **Authorization; noninsurers.** If an authorization is submitted to an insurer, insurance-support organization, or insurance agent by a person other than an insurer, insurance-support organization, or insurance agent, the authorization must be dated, signed by the person, and obtained one year or less before the date a disclosure is sought.

History: *1989 c 316 s 13*

72A.502 DISCLOSURE OF INFORMATION; LIMITATIONS AND CONDITIONS.

Subdivision 1. **Requirement.** An insurer, insurance agent, or insurance-support organization must not disclose any personal or privileged information about a person collected or received in connection with an insurance transaction without the written authorization of that person except as authorized by this section. An insurer, insurance agent, or insurance-support organization must not collect personal information about a policyholder or an applicant not relating to a claim from sources other than public records without a written authorization from the person.

Subd. 2. **Prevention of fraud.** Personal or privileged information may be disclosed without a written authorization to another person if the information is limited to that which is reasonably necessary to detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction, and that person agrees not to disclose the information further without the individual written authorization unless the further disclosure is otherwise permitted by this section if made by an insurer, insurance agent, or insurance-support organization.

Subd. 3. **Health care institutions and professionals.** Personal or privileged information may be disclosed without a written authorization to a health care institution or health professional for the purpose of verifying insurance coverage benefits, informing a person of a health problem of which the person must not be aware, or conducting an operations or services audit, if the information is only disclosed that is reasonably necessary to accomplish the purposes under this subdivision.

Subd. 4. **Regulatory authority.** Personal or privileged information may be disclosed without a written authorization to an insurance regulatory authority.

Subd. 5. **Other governmental authorities.** Personal or privileged information may be disclosed without a written authorization to a law enforcement or other governmental authority if:

(1) the disclosure is to protect the interests of the insurer, agent, or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or

(2) the insurer, agent, or insurance-support organization reasonably believes that illegal activities have been conducted by the individual.

Subd. 6. **Other laws or order.** Personal or privileged information may be disclosed without a written authorization if permitted or required by another law or in response to a facially valid administrative or judicial order, including a search warrant or subpoena.

Subd. 7. **Actuarial and research studies.** Personal or privileged information may be disclosed without a written authorization to conduct actuarial or research studies if:

(1) no individual may be identified in the actuarial or research report;

(2) materials allowing an individual to be identified are returned or destroyed as soon as they are no longer needed; and

(3) the actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance company, agent, or insurance-support organization.

Subd. 8. **Affiliate companies.** Personal or privileged information may be disclosed without a written authorization to an affiliate whose only use of the information will be in connection with an audit of the insurer or agent or the marketing of an insurance product or service, provided the affiliate agrees to not disclose the information for any other purpose or to unaffiliated persons.

Subd. 9. **Group policyholder.** Personal or privileged information may be disclosed with written authorization to a group policyholder only to report claims experience or conduct an audit of the insurer's or agent's operations or services, if the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

Subd. 10. **Governmental licensing board.** Personal or privileged information may be disclosed without a written authorization to a governmental professional licensing or regulatory board to review the service or conduct of a health care institution or health professional that the insurer has reason to believe has violated its licensing act or engaged in the unlawful practice of a licensed professional.

Subd. 11. **Professional peer review.** Subject to the terms of a contract between an insurer and a health professional or health care institution, personal or privileged information may be disclosed without a written authorization to a professional peer review organization to review the service or conduct of a health care institution or health professional.

Subd. 12. **Notice.** Whenever an insurer, insurance agent, or insurance-support organization discloses personal or privileged information about a person that requires the written authorization of that person under this section, the insurer, insurance agent, or insurance-support organization shall notify that person in writing within ten days of the date the information was disclosed. The notification must specify the identity of the person to whom information was disclosed and the nature and substance of the information that was disclosed. A notice is not required to be given under this subdivision if an insurer is disclosing personal information for underwriting purposes to another insurer, or to an insurance-support organization if the person had signed an authorization authorizing the disclosure.

History: *1989 c 316 s 14*

72A.503 PRIVATE REMEDIES.

Subdivision 1. **Liability.** Any insurer, insurance agent, or insurance-support organization that violates sections 72A.49 to 72A.505 is liable to the aggrieved person for that violation to the same extent as civil remedies are otherwise allowed in section 13.08, subdivision 1, for violations of chapter 13, by a political subdivision, responsible authority, statewide system, or statewide agency.

Subd. 2. **Equitable relief.** Upon application by an aggrieved person, a court of competent jurisdiction may grant equitable and declaratory relief as necessary to enforce the requirements of sections 72A.49 to 72A.505.

History: *1989 c 316 s 15*

72A.504 OBTAINING INFORMATION UNDER IMPROPER MEANS.

Any person who knowingly and willfully obtains information about a person in violation of section 72A.493 is subject to a fine not to exceed $3,000 or imprisonment not to exceed one year, or both.

History: *1989 c 316 s 16*

72A.505 IMMUNITY.

No cause of action in the nature of defamation, invasion of privacy, or negligence may arise against an insurer, insurance agent, or insurance-support organization for disclosing personal or privileged information required to be disclosed under sections 72A.20, subdivision 11, and 72A.49 to 72A.504, provided no immunity exists for disclosing false information with malice or willful intent to injure any person.

History: *1989 c 316 s 17*