Subd. 3. The conversion of public funds for the benefit of any individual shall constitute grounds for review and action by the attorney general or the county attorney under section 609.54.

Subd. 4. Notwithstanding the development of an organization under this section, the governance of a hospital by the organization shall be subject to the public purchasing requirements of section 471.345, the open meeting law, section 471.705, and the data practices act, chapter 13.

Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective the day following final enactment.

Approved April 25, 1984

CHAPTER 555 — S.F.No. 1862

An act relating to insurance; regulating insurance claims settlement; defining terms; prescribing penalties; providing for the venue for certain injunction proceedings; amending Minnesota Statutes 1982, sections 72A.20, subdivisions 11 and 12, and by adding a subdivision; 72A.23, subdivision 1; and 72A.25, subdivision 2.

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

Section 1. Minnesota Statutes 1982, section 72A.20, subdivision 11, is amended to read:

Subd. 11. **APPLICATION TO CERTAIN SECTIONS.** Violating any provision of the following sections of this chapter not set forth in subdivisions 1 to ~~10~~ 15 shall constitute an unfair method of competition and an unfair and deceptive act or practice: section 72A.12, subdivisions 2, 3, and 4, section 72A.16, subdivision 2, sections 72A.03 and 72A.04, section 72A.08, subdivision 1 as modified by section 72A.08, subdivision 4, and section 65B.13.

Sec. 2. Minnesota Statutes 1982, section 72A.20, subdivision 12, is amended to read:

Subd. 12. **UNFAIR SERVICE.** Causing or permitting with such frequency to indicate a general business practice ~~the claims and complaints of insureds to be processed in an unreasonable length of time, or in an unfair, deceptive, or fraudulent manner, or in violation of such rules as the commissioner of insurance shall make in the public interest to insure the prompt, fair, and honest processing of such claims and complaints, shall constitute an unfair method of competition and an unfair and deceptive act or practice~~ any unfair, deceptive, or fraudulent act concerning any claim or complaint of an insured or claimant including, but not limited to, the following practices:

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(1) misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;

(10) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(11) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(14) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

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Sec. 3. Minnesota Statutes 1982, section 72A.20, is amended by adding a subdivision to read:

Subd. 12a. **CLAIMS SETTLEMENT.** (a) **ADMINISTRATIVE ENFORCEMENT.** The commissioner may, in accordance with chapter 14, adopt rules to insure the prompt, fair, and honest processing of claims and complaints. The commissioner may, in accordance with sections 72A.22 to 72A.25, seek and impose appropriate administrative remedies, including fines, for (1) a violation of this subdivision or the rules adopted pusuant to this subdivision; or (2) a violation of section 72A.20, subdivision 12. The commissioner need not show a general business practice in taking an administrative action for these violations.

No individual violation constitutes an unfair, discriminatory, or unlawful practice in business, commerce, or trade for purposes of section 8.31.

(b) **CONSTRUCTION.** The policy of the department of commerce, in interpreting and enforcing this subdivision, will be to take into consideration all pertinent facts and circumstances in determining the severity and appropriateness of the action to be taken in regard to any violation of this subdivision.

The magnitude of the harm to the claimant or insured, and any actions by the insured, claimant, or insurer that mitigate or exacerbate the impact of the violation may be considered.

Actions of the claimant or insured which impeded the insurer in processing or settling the claim, and actions of the insurer which increased the detriment to the claimant or insured may also be considered in determining the appropriate administrative action to be taken.

(c) **DEFINITIONS.** For the purposes of this subdivision, the following terms have the meanings given them.

(1) Adjuster or adjusters. "Adjuster" or "adjusters" is as defined in Minnesota Statutes, section 72B.02.

(2) Agent. "Agent" means insurance agents or insurance agencies licensed pursuant to Minnesota Statutes, section 60A.17, and representatives of these agents or agencies.

(3) Claim. "Claim" means a request or demand made with an insurer for the payment of funds or the provision of services under the terms of any policy, certificate, contract of insurance, binder, or other contracts of temporary insurance. The term does not include a claim under a health insurance policy made by a participating provider with an insurer in accordance with the participating provider's service agreement with the insurer which has been filed with the commissioner of commerce prior to its use.

(4) Claim settlement. "Claim settlement" means all activities of an insurer related directly or indirectly to the determination of the extent of

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liabilities due or potentially due under coverages afforded by the policy, and which result in claim payment, claim acceptance, compromise, or other disposition.

(5) Claimant. "Claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity which is insured under an insurance policy or insurance contract of an insurer.

(6) Complaint. "Complaint" means a communication primarily expressing a grievance.

(7) Insurance policy. "Insurance policy" means any evidence of coverage issued by an insurer including all policies, contracts, certificates, riders, binders, and endorsements which provide or describe coverage. The term includes any contract issuing coverage under a self-insurance plan, group self-insurance plan, or joint self-insurance employee health plans.

(8) Insured. "Insured" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment under their insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract. The term does not apply to a person who acquires rights under a mortgage.

(9) Insurer. "Insurer" includes any individual, corporation, association, partnership, reciprocal exchange, Lloyds, fraternal benefits society, self-insurer, surplus line insurer, self-insurance administrator, and nonprofit service plans under the jurisdiction of the department of commerce.

(10) Investigation. "Investigation" means a reasonable procedure adopted by an insurer to determine whether to accept or reject a claim.

(11) Notification of claim. "Notification of claim" means any communication to an insurer by a claimant or an insured which reasonably apprises the insurer of a claim brought under an insurance contract or policy issued by the insurer. Notification of claim to an agent of the insurer is notice to the insurer.

(12) Proof of loss. "Proof of loss" means the necessary documentation required from the insured to establish entitlement to payment under a policy.

(13) Self-insurance administrator. "Self-insurance administrator" means any vendor of risk management services or entities administering self-insurance plans, licensed pursuant to Minnesota Statutes, section 60A.23, subdivision 8.

(14) Self-insured or self-insurer. "Self-insured" or "self-insurer" means any entity authorized pursuant to Minnesota Statutes, section 65B.48, subdivision 3; Minnesota Statutes, chapter 62H; Minnesota Statutes, section 176.181, subdivision 2; Laws of Minnesota 1983, chapter 290, section 171; Minnesota Statutes, section 471.617; or Minnesota Statutes, section 471.981 and includes any entity

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which, for a fee, employs the services of vendors of risk management services in the administration of a self-insurance plan as defined by Minnesota Statutes, 60A.23, subdivision 8, clause (2), subclauses (a) and (d).

(d) **STANDARDS FOR CLAIM FILING AND HANDLING.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) except for claims made under a health insurance policy, after receiving notification of claim from an insured or a claimant, failing to acknowledge receipt of the notification of the claim within ten business days, and failing to promptly provide all necessary claim forms and instructions to process the claim, unless the claim is settled within ten business days. The acknowledgment must include the telephone number of the company representative who can assist the insured or the claimant in providing information and assistance that is reasonable so that the insured or claimant can comply with the policy conditions and the insurer's reasonable requirements. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer and dated. An appropriate notation must include at least the following information where the acknowledgment is by telephone or oral contact:

(i) the telephone number called, if any;

(ii) the name of the person making the telephone call or oral contact;

(iii) the name of the person who actually received the telephone call or oral contact;

(iv) the time of the telephone call or oral contact; and

(v) the date of the telephone call or oral contact;

(2) failing to reply, within ten business days of receipt, to all other communications about a claim from an insured or a claimant that reasonably indicate a response is requested or needed;

(3) unless provided otherwise by law or in the policy, failing to complete its investigation and inform the insured or claimant of acceptance or denial of a claim within 30 business days after receipt of notification of claim unless the investigation cannot be reasonably completed within that time. In the event that the investigation cannot reasonably be completed within that time, the insurer shall notify the insured or claimant within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. For claims made under a health policy the notification of claim must be in writing;

(4) where evidence of suspected fraud is present, the requirement to disclose their reasons for failure to complete the investigation within the time

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period set forth in clause (3) need not be specific. The insurer must make this evidence available to the department of commerce if requested;

(5) failing to notify an insured who has made a notification of claim of all available benefits or coverages which he or she may be eligible to receive under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;

(6) unless otherwise provided by law or in the policy, requiring an insured to give written notice of loss or proof of loss within a specified time, and thereafter seeking to relieve the insurer of its obligations if the time limit is not complied with, unless the failure to comply with the time limit prejudices the insurer's rights and then only if the insurer gave prior notice to the insured of the potential prejudice;

(7) advising an insured or a claimant not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or an adjuster is retained by the insured or the claimant;

(8) failing to advise in writing an insured or claimant who has filed a notification of claim known to be unresolved, and who has not retained an attorney, of the expiration of a statute of limitations at least 60 days prior to that expiration. For the purposes of this clause, any claim on which the insurer has received no communication from the insured or claimant for a period of two years preceding the expiration of the applicable statute of limitations shall not be considered to be known to be unresolved and notice need not be sent pursuant to this clause;

(9) demanding information which would not affect the settlement of the claim;

(10) unless expressly permitted by law or the policy, refusing to settle a claim of an insured on the basis that the responsibility should be assumed by others;

(11) failing, within 60 business days after receipt of a properly executed proof of loss, to advise the insured of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial must be given to the insured in writing with a copy filed in the claim file;

(12) denying or reducing a claim on the basis of an application which was altered or falsified by the agent or insurer without the knowledge of the insured;

(13) failing to notify the insured of the existence of the additional living expense coverage when an insured under a homeowners policy sustains a loss by reason of a covered occurrence and the damage to the dwelling is such that it is not habitable;

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(14) failing to inform an insured or a claimant that the insurer will pay for an estimate of repair if the insurer requested the estimate and the insured or claimant had previously submitted two estimates of repair.

(e) **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) 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.

(f) **STANDARDS FOR AUTOMOBILE INSURANCE CLAIMS HANDLING, SETTLEMENT OFFERS, AND AGREEMENTS.** In addition to the

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acts specified in paragraphs (d), (e), (g), (h), and (i), 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;

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(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 acknowledgement 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. 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;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that he or she 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 Minnesota Statutes, 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 Minnesota Statutes, section 65B.56, subdivision 1, failing to notify the insured of all of his or her rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination.

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(g) **STANDARDS FOR RELEASES.** The following acts by an insurer, adjuster, or self-insured or self-insurance administrator constitute unfair settlement practices:

(1) requesting or requiring an insured or a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

(2) issuing a check or draft in payment of a claim that contains any language or provision that implies or states that acceptance of the check or draft constitutes a final settlement or release of any or all future obligations arising out of the loss.

(h) **STANDARDS FOR CLAIM DENIAL.** The following acts by an insurer, adjuster, or self-insured, or self-insurance administrator constitute unfair settlement practices:

(1) denying a claim or any element of a claim on the grounds of a specific policy provision, condition, or exclusion, without informing the insured of the policy provision, condition, or exclusion on which the denial is based;

(2) denying a claim without having made a reasonable investigation of the claim;

(3) denying a liability claim because the insured has requested that the claim be denied;

(4) denying a liability claim because the insured has failed or refused to report the claim, unless an independent evaluation of available information indicates there is no liability;

(5) denying a claim without including the following information:

(i) the basis for the denial;

(ii) the name, address, and telephone number of the insurer's claim service office or the claim representative of the insurer to whom the insured or claimant may take any questions or complaints about the denial; and

(iii) the claim number and the policy number of the insured;

(6) denying a claim because the insured or claimant failed to exhibit the damaged property unless:

(i) the insurer, within a reasonable time period, made a written demand upon the insured or claimant to exhibit the property; and

(ii) the demand was reasonable under the circumstances in which it was made.

(i) **STANDARDS FOR COMMUNICATIONS WITH THE DEPARTMENT.** In addition to the acts specified elsewhere in this section, the following

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acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) failure to respond, within 15 working days after receipt of an inquiry from the commissioner, about a claim, to the commissioner;

(2) failure, upon request by the commissioner, to make specific claim files available to the commissioner;

(3) failure to include in the claim file all written communications and transactions emanating from, or received by, the insurer, as well as all notes and work papers relating to the claim. All written communications and notes referring to verbal communications must be dated by the insurer;

(4) failure to submit to the commissioner, when requested, any summary of complaint data reasonably required;

(5) failure to compile and maintain a file on all complaints. If the complaint deals with a loss, the file must contain adequate information so as to permit easy retrieval of the entire file. If the complaint alleges that the company, or agent of the company, or any agent producing business written by the company is engaged in any unfair, false, misleading, dishonest, fraudulent, untrustworthy, coercive, or financially irresponsible practice, or has violated any insurance law or rule, the file must indicate what investigation or action was taken by the company. The complaint file must be maintained for at least four years after the date of the complaint.

(j) **SCOPE.** This subdivision does not apply to workers' compensation insurance. Nothing in this subdivision abrogates any policy provisions.

Sec. 4. Minnesota Statutes 1982, section 72A.23, subdivision 1, is amended to read:

Subdivision 1. **DETERMINATION BY COMMISSIONER; FINDINGS.** Whenever it appears to the commissioner that any person has engaged or is about to engage in any act or practice constituting a violation of this chapter or any rule or order hereunder:

(a) He may issue and cause to be served upon the person an order requiring the person to cease and desist from violations of section 72A.19 or 72A.20. The order must be calculated to give reasonable notice of the rights of the person to request a hearing thereon and must state the reasons for the entry of the order. A hearing must be held not later than seven days after the request for the hearing is received by the commissioner after which and within 20 days of the date of the hearing the commissioner shall issue a further order vacating the cease and desist order or making it permanent as the facts require. If no hearing is requested within 30 days of service of the order, the order will become final and will remain in effect until it is modified or vacated by the commissioner. All hearings must be conducted in accordance with the provisions of chapter 14. If

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the person to whom a cease and desist order is issued fails to appear at the hearing after being duly notified, the person shall be deemed in default, and the proceeding may be determined against him upon consideration of the cease and desist order, the allegations of which may be deemed to be true. The commissioner may adopt rules of procedure concerning all proceedings conducted pursuant to this subdivision; and

(b) If, after a hearing, as provided in section 72A.22, the commissioner shall determine that the method of competition or the act or practice in question is defined in section 72A.20 or any rules adopted pursuant to section 72A.19 or 72A.20, and that the person complained of has engaged in that method of competition, act, or practice, in violation of sections 72A.17 to 72A.32 he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation an order requiring him to cease and desist from engaging in that method of competition, act or practice, and may impose a civil penalty of not more than $2,000 for each offense. If the commissioner determines that an insurer has engaged in an act or practice defined in section 72A.20, subdivision 13, the cease and desist order may also require the insurer to write or renew the homeowner's insurance coverage sought by the insured or prospective insured for a specified period of up to three years without cancellation or nonrenewal by the insurer for a reason not specified in section 65A.01; after the specified period expires, cancellation or nonrenewal of the coverage may be made only as permitted by law.

Sec. 5. Minnesota Statutes 1982, section 72A.25, subdivision 2, is amended to read:

Subd. 2. **APPLICATION FOR INJUNCTION.** If the report charges a violation of sections 72A.17 to 72A.32 and if the method of competition, act, or practice charged by him has not been discontinued, the commissioner may, through the attorney general, at any time after 20 days after the service of the report, cause a petition to be filed in the district court ~~within the district wherein the person against whom the charges were made resides, or that wherein he has his principal place of business~~ of Ramsey County, to enjoin and restrain that person from engaging in the method, act, or practice charged. A transcript of the proceedings before the commissioner, including all evidence taken and the report and findings, shall be filed with the petition. Upon the filing of the petition and transcript the court shall have jurisdiction of the proceedings and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or necessary in its judgment to prevent injury to the public pendente lite.

Sec. 6. **EFFECTIVE DATE.**

Sections 1 to 5 are effective the day following final enactment.

Approved April 25, 1984

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