CHAPTER 72A

REGULATION OF TRADE PRACTICES

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72A.061 MANDATORY FILINGS; FAILURE TO COMPLY; PENALTIES.

Subdivision 1. **Annual statements.** Any insurance company licensed to do business in this state, including fraternals, reciprocals and township mutuals, which neglects to file its annual statement in the form prescribed and within the time specified by law shall be subject to a penalty of $100 for each day in default. If, at the end of 45 days, the default has not been corrected, the company shall be given ten days in which to show cause to the commissioner why its license should not be suspended. If the company has not made the requisite showing within the ten-day period, the license and authority of the company may, at the discretion of the commissioner, be suspended during the time the company is in default.

Any insurance company, including fraternals, reciprocals, and township mutuals, willfully making a false annual or other required statement shall pay a penalty to the state not to exceed $5,000. Either or both of the monetary penalties imposed by this subdivision may be recovered in a civil action brought by and in the name of the state.

[For text of subds 2 to 6, see M.S.1990]

History: *1991 c 325 art 10 s 10*

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

[For text of subds 1 to 7, see M.S.1990]

Subd. 8. **Discrimination.** (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract or in making or permitting the rejection of an individual's application for life insurance coverage, as well as the determination of the rate class for such individual, on the basis of a disability, shall constitute an unfair method of competition and an unfair and deceptive act or practice, unless the claims experience and actuarial projections and other data establish significant and substantial differences in class rates because of the disability.

(b) Refusing to insure or refusing to continue to insure the life of a member of a reserve component of the armed forces of the United States, or the national guard due to that person's status as a member, or duty assignment while a member of any of these military organizations, constitutes an unfair method of competition and an unfair and deceptive act or practice unless the individual has received an order for active duty.

(c) Refusing to reinstate coverage for the insured or any covered dependents under an individual or group life or health insurance policy or contract of a member of a reserve component of the armed forces of the United States or the national guard whose coverage or dependent coverage was terminated, canceled, or nonrenewed while that person was on active duty constitutes an unfair method of competition and an unfair and deceptive act or practice. For purposes of this section, "health insurance policy or contract" means any policy, contract, or certificate providing benefits regulated under chapter 62A, 62C, 62D, or 64B.

For purposes of reinstatement of an individual policy, the person shall apply for reinstatement within 90 days after removal from active duty.

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The reinstated coverage must not contain any new preexisting condition or other exclusion or limitation, except a condition determined by the Veterans Administration to be a disability incurred or aggravated in the line of duty. The remainder of a preexisting condition limitation that was not satisfied before the coverage was terminated may be applied once the person returns and coverage is reinstated. Reinstatement is effective upon the payment of any required premiums.

[For text of subds 9 to 27, see M.S.1990]

History: *1991 c 188 s 1*

72A.201 REGULATION OF CLAIMS PRACTICES.

[For text of subds 1 to 5, see M.S.1990]

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;

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(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;

(13) failing to provide, to an insured who has submitted a claim for benefits described in section 65B.44, a complete copy of the insurer's claim file on the insured, excluding internal company memoranda, all materials that relate to any insurance fraud investigation, materials that constitute attorney work-product or that qualify for the attorney-client privilege, and medical reviews that are subject to section 145.64, within ten business days of receiving a written request from the insured. The insurer may charge the insured a reasonable copying fee. This clause supersedes any inconsistent provisions of sections 72A.49 to 72A.505;

(14) if an automobile policy provides for the adjustment or settlement of an automobile loss due to damaged window glass, failing to assume all costs sufficient to pay the insured's chosen vendor for the replacement of comparable window glass at a price generally available in the area. This clause does not prohibit an insurer from recommending a vendor to the insured or from agreeing with a vendor to perform work at an agreed-upon price.

[For text of subd 7, see M.S.1990]

Subd. 8. **Standards for claim denial.** The following acts by an insurer, adjuster, or self-insured, or self-insurance administrator constitute unfair settlement practices:

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(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;

(7) denying a claim by an insured or claimant based on the evaluation of a chemical dependency claim reviewer selected by the insurer unless the reviewer meets the qualifications specified under subdivision 8a. An insurer that selects chemical dependency reviewers to conduct claim evaluations must annually file with the commissioner of commerce a report containing the specific evaluation standards and criteria used in these evaluations. The report must also include the number of evaluations performed on behalf of the insurer during the reporting period, the types of evaluations performed, the results, the number of appeals of denials based on these evaluations, the results of these appeals, and the number of complaints filed in a court of competent jurisdiction.

Subd. 8a. **Chemical dependency claim reviewer qualifications.** (a) The personnel file of a chemical dependency claim reviewer must include documentation of the individual's competency in the following areas:

(1) knowledge of chemical abuse and dependency;

(2) chemical use assessment, including client interviewing and screening;

(3) case management, including treatment planning, general knowledge of social services, and appropriate referrals, and record keeping, reporting requirements, and confidentiality rules and regulations that apply to chemical dependency clients; and

(4) individual and group counseling, including crisis intervention.

(b) The insurer may accept one of the following as adequate documentation that a chemical dependency claim reviewer is competent in the areas required under paragraph (a):

(1) the individual has at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, is a licensed registered nurse, or is a licensed physician; has successfully completed 30 hours of classroom instruction in each of the areas identified in paragraph (a), clauses (1) and (2); and has successfully completed 480 hours of supervised experience as a chemical dependency counselor, either as a student or as an employee; or

(2) the individual has documented the successful completion of the following:

(i) 60 hours of classroom training in the subject area identified in paragraph (a), clause (1);

(ii) 30 hours of classroom training in the subject area identified in paragraph (a), clause (2);

(iii) 160 hours of classroom training in the subject areas identified in paragraph (a), clauses (3) and (4); and

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(iv) completion of 480 hours of supervised experience as a chemical dependency counselor, either as a student or as an employee; or

(3) the individual is certified by the Institute for Chemical Dependency Professionals of Minnesota, Inc., as a chemical dependency counselor or as a chemical dependency counselor reciprocal, through the evaluation process established by the Certification Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1986;

(4) the individual successfully completed three years of supervised work experience as a chemical dependency counselor before January 1, 1988; or

(5) the individual is a licensed physician, who has 480 hours of experience in a licensed chemical dependency program.

After January 1, 1993, chemical dependency counselors must document that they meet the requirements of clause (1), (2), or (3) in order to comply with this paragraph.

[For text of subds 9 to 12, see M.S.1990]

History: *1991 c 115 s 1,2; 1991 c 131 s 2; 1991 c 207 s 7*

72A.206 IMPAIRMENT OR INSOLVENCY; NOTICE OF LIMITATIONS AND EXCLUSIONS OF PROTECTION.

(a) No person, including an insurer, agent, or affiliate of an insurer or agent shall sell, or offer for sale, a policy or contract of insurance of any kind unless a separate notice conforming to the requirements of paragraph (b) is delivered with the application for that policy or contract. The notice is considered part of the policy or contract and must be signed by the applicant and kept on file by the insurer. A copy of the signed notice must be given to the applicant. This section does not apply to renewals, unless the renewal increases the dollar amount of a coverage by more than 100 percent.

(b) The notice must clearly state the limitations and exclusions relating to the protection afforded the policy or contract holder should the insurer become financially impaired or insolvent, including coverages afforded by any guaranty fund.

(c) The notice requirements of section 61B.12, subdivision 6, supersede the requirements of this section. With respect to combination fixed-variable policies, the notice requirement of section 61B.12, subdivision 6, supersedes the requirements of this section, provided that the notice provided under section 61B.12, subdivision 6, clearly describes what portions of the policy are not covered by the guaranty fund.

(d) This section does not apply to fraternal benefit societies regulated under chapter 64B.

History: *1991 c 325 art 21 s 8*

72A.285 CLAIM FOR INSURANCE BENEFITS; RELEASE OF SUMMARY INFORMATION.

Notwithstanding section 145.64, when a review organization, as defined in section 145.61, has conducted a review of health services given or proposed to be given to an insured or claimant in connection with or in anticipation of a claim for insurance benefits, a complete summary of the review findings must be furnished by the insurer to the provider who requested the review or to the insured or claimant, upon that person's request.

The summary must list the qualifications of the reviewer, including any license, certification, or specialty designation. The summary must also describe the relationship between the insured's or claimant's diagnosis and the review criteria used as a basis for the claim decision, including the specific rationale for the reviewer's decision.

Nothing in this section requires the disclosure of the identity of the person conducting the review.

History: *1991 c 264 s 3*

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