CHAPTER 72A

REGULATION OF TRADE PRACTICES

72A.139 USE OF GENETIC TESTS.

Subdivision 1. **Name and citation.** This section shall be known and may be cited as the "genetic discrimination act."

Subd. 2. **Definitions.** (a) As used in this section, "commissioner" means the commissioner of commerce for health plan companies and other insurers regulated by that commissioner and the commissioner of health for health plan companies regulated by that commissioner.

(b) As used in this section, a "genetic test" means a presymptomatic test of a person's genes, gene products, or chromosomes for the purpose of determining the presence or absence of a gene or genes that exhibit abnormalities, defects, or deficiencies, including carrier status, that are known to be the cause of a disease or disorder, or are determined to be associated with a statistically increased risk of development of a disease or disorder. "Genetic test" does not include a cholesterol test or other test not conducted for the purpose of determining the presence or absence of a person's gene or genes.

(c) As used in this section, "health plan" has the meaning given in section 62Q.01, subdivision 3.

(d) As used in this section, "health plan company" has the meaning given in section 62Q.01, subdivision 4.

(e) As used in this section, "individual" means an applicant for coverage or a person already covered by the health plan company or other insurer.

Subd. 3. **Prohibited acts; health plan companies.** A health plan company, in determining eligibility for coverage, establishing premiums, limiting coverage, renewing coverage, or any other underwriting decision, shall not, in connection with the offer, sale, or renewal of a health plan:

(1) require or request an individual or a blood relative of the individual to take a genetic test;

(2) make any inquiry to determine whether an individual or a blood relative of the individual has taken or refused a genetic test, or what the results of any such test were;

(3) take into consideration the fact that a genetic test was taken or refused by an individual or blood relative of the individual; or

(4) take into consideration the results of a genetic test taken by an individual or a blood relative of the individual.

Subd. 4. **Application.** Subdivisions 5, 6, and 7 apply only to a life insurance company or fraternal benefit society requiring a genetic test for the purpose of determining insurability under a policy of life insurance.

Subd. 5. **Informed consent.** If an individual agrees to take a genetic test, the life insurance company or fraternal benefit society shall obtain the individual's written informed consent for the test. Written informed consent must include, at a minimum, a description of the specific test to be performed; its purpose, potential uses, and limitations; the meaning of its results; and the right to confidential treatment of the results. The written informed consent must inform the individual that the individual should consider consulting with a genetic counselor prior to taking the test and must state whether the insurer will pay for any such consultation. An informed consent disclosure form must be approved by the commissioner prior to its use.

Subd. 6. **Notification.** The life insurance company or fraternal benefit society shall notify an individual of a genetic test result by notifying the individual or the individual's designated physician. If the individual tested has not given written consent authorizing a physi-

cian to receive the test results, the individual must be urged, at the time that the individual is informed of the genetic test result described in this subdivision, to contact a genetic counselor or other health care professional.

Subd. 7. **Payment for test.** A life insurance company or fraternal benefit society shall not require an individual to submit to a genetic test unless the cost of the test is paid by the life insurance company or fraternal benefit society.

Subd. 8. **Enforcement.** A violation of this section is subject to the investigative and enforcement authority of the commissioner, who shall enforce this section.

History: *1995 c 251 s 1*

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

[For text of subds 1 to 12, see M.S.1994]

Subd. 13. **Refusal to renew.** Refusing to renew, declining to offer or write, or charging differential rates for an equivalent amount of homeowner's insurance coverage, as defined by section 65A.27, for property located in a town or statutory or home rule charter city, in which the insurer offers to sell or writes homeowner's insurance, solely because:

(a) of the geographic area in which the property is located;

(b) of the age of the primary structure sought to be insured;

(c) the insured or prospective insured was denied coverage of the property by another insurer, whether by cancellation, nonrenewal or declination to offer coverage, for a reason other than those specified in section 65A.01, subdivision 3a, clauses (a) to (e); or

(d) the property of the insured or prospective insured has been insured under the Minnesota FAIR plan act, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

This subdivision prohibits an insurer from filing or charging different rates for different zip code areas within the same town or statutory or home rule charter city.

This subdivision shall not prohibit the insurer from applying underwriting or rating standards which the insurer applies generally in all other locations in the state and which are not specifically prohibited by clauses (a) to (d). Such underwriting or rating standards shall specifically include but not be limited to standards based upon the proximity of the insured property to an extraordinary hazard or based upon the quality or availability of fire protection services or based upon the density or concentration of the insurer's risks. Clause (b) shall not prohibit the use of rating standards based upon the age of the insured structure's plumbing, electrical, heating or cooling system or other part of the structure, the age of which affects the risk of loss. Any insurer's failure to comply with section 65A.29, subdivisions 2 to 4, either (1) by failing to give an insured or applicant the required notice or statement or (2) by failing to state specifically a bona fide underwriting or other reason for the refusal to write shall create a presumption that the insurer has violated this subdivision.

[For text of subds 14 to 28, see M.S.1994]

Subd. 29. **HIV tests; crime victims.** No insurer regulated under chapter 61A or 62B, or providing health, medical, hospitalization, or accident and sickness insurance regulated under chapter 62A, or nonprofit health services corporation regulated under chapter 62C, health maintenance organization regulated under chapter 62D, or fraternal benefit society regulated under chapter 64B, may:

(1) obtain or use the performance of or the results of a test to determine the presence of the human immune deficiency virus (HIV) antibody performed on an offender under section 611A.19 or performed on a crime victim who was exposed to or had contact with an offender's bodily fluids during commission of a crime that was reported to law enforcement officials, in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate, or contract;

(2) obtain or use the performance of or the results of a test to determine the presence of the human immune deficiency virus (HIV) antibody performed on a patient pursuant to sec-

tions 144.761 to 144.7691, or performed on emergency medical services personnel pursuant to the protocol under section 144.762, subdivision 2, in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate, or contract; for purposes of this clause, "patient" and "emergency medical services personnel" have the meanings given in section 144.761; or

(3) ask an applicant for coverage or a person already covered whether the person has: (i) had a test performed for the reason set forth in clause (1) or (2); or (ii) been the victim of an assault or any other crime which involves bodily contact with the offender.

A question that purports to require an answer that would provide information regarding a test performed for the reason set forth in clause (1) or (2) may be interpreted as excluding this test. An answer that does not mention the test is considered to be a truthful answer for all purposes. An authorization for the release of medical records for insurance purposes must specifically exclude any test performed for the purpose set forth in clause (1) or (2) and must be read as providing this exclusion regardless of whether the exclusion is expressly stated. This subdivision does not affect tests conducted for purposes other than those described in clause (1) or (2), including any test to determine the presence of the human immune deficiency virus (HIV) antibody if such test was performed at the insurer's direction as part of the insurer's normal underwriting requirements.

[For text of subds 30 and 31, see M.S.1994]

Subd. 32. **Unfair health risk avoidance.** No insurer or health plan company may design a network of providers, policies on access to providers, or marketing strategy in such a way as to discourage enrollment by individuals or groups whose health care needs are perceived as likely to be more expensive than the average. This subdivision does not prohibit underwriting and rating practices that comply with Minnesota law.

Subd. 33. **Prohibition of inappropriate incentives.** No insurer or health plan company may give any financial incentive to a health care provider based solely on the number of services denied or referrals not authorized by the provider. This subdivision does not prohibit capitation or other compensation methods that serve to hold health care providers financially accountable for the cost of caring for a patient population.

Subd. 34. **Suitability of insurance for customer.** In recommending or issuing life, endowment, individual accident and sickness, long–term care, annuity, life–endowment, or Medicare supplement insurance to a customer, an insurer, either directly or through its agent, must have reasonable grounds for believing that the recommendation is suitable for the customer.

In the case of group insurance marketed on a direct response basis without the use of direct agent contact, this subdivision is satisfied if the insurer has reasonable grounds to believe that the insurance offered is generally suitable for the group to whom the offer is made.

History: *1995 c 186 s 17; 1995 c 234 art 8 s 21,22; 1995 c 258 s 52,53*

72A.201 REGULATION OF CLAIMS PRACTICES.

[For text of subds 1 to 12, see M.S.1994]

Subd. 13. **Improper claim of discount.** (a) No insurer, integrated service network, or community integrated service network shall intentionally provide a health care provider with an explanation of benefits or similar document claiming a right to a discounted fee, price, or other charge, when the insurer, integrated service network, or community integrated service network does not have an agreement with the provider for the discount with respect to the patient involved.

(b) The insurer, integrated service network, or community integrated service network may, notwithstanding paragraph (a), claim the right to a discount based upon a discount agreement between the health care provider and another entity, but only if:

(1) that agreement expressly permitted the entity to assign its right to receive the discount;

(2) an assignment to the insurer, integrated service network, or community integrated service network of the right to receive the discount complies with any relevant requirements for assignments contained in the discount agreement; and

(3) the insurer, integrated service network, or community integrated service network has complied with any relevant requirements contained in the assignment.

(c) When an explanation of benefits or similar document claims a discount permitted under paragraph (b), it shall prominently state that the discount claimed is based upon an assignment and shall state the name of the entity from whom the assignment was received. This paragraph does not apply if the entity that issues the explanation of benefits or similar document has a provider agreement with the provider.

(d) No insurer, integrated service network, or community integrated service network that has entered into an agreement with a health care provider that involves discounted fees, prices, or other charges shall disclose the discounts to another entity, with the knowledge or expectation that the disclosure will result in claims for discounts prohibited under paragraphs (a) and (b).

History: *1995 c 234 art 7 s 27*