CHAPTER 72A

REGULATION OF TRADE PRACTICES

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

[For text of subds 1 to 12, see M.S.2004]

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);

(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; or

(e) the insured has inquired about coverage for a hypothetical claim or has made an inquiry to the insured's agent regarding a potential claim.

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 (e). 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 35, see M.S.2004]

Subd. 36. **Limitations on the use of credit information.** (a) No insurer or group of affiliated insurers may reject, cancel, or nonrenew a policy of private passenger motor vehicle insurance as defined under section 65B.01 or a policy of homeowner's insurance as defined under section 65A.27, for any person in whole or in part on the basis of credit information, including a credit reporting product known as a "credit score" or "insurance score," without consideration and inclusion of any other applicable underwriting factor.

(b) If credit information, credit scoring, or insurance scoring is to be used in underwriting, the insurer must disclose to the consumer that credit information will be obtained and used as part of the insurance underwriting process.

(c) Insurance inquiries and non-consumer-initiated inquiries must not be used as part of the credit scoring or insurance scoring process.

(d) If a credit score, insurance score, or other credit information relating to a consumer, with respect to the types of insurance referred to in paragraph (a), is adversely impacted or cannot be generated because of the absence of a credit history, the insurer must exclude the use of credit as a factor in the decision to reject, cancel, or nonrenew.

(e) Insurers must upon the request of a policyholder reevaluate the policyholder's score. Any change in premium resulting from the reevaluation must be effective upon the renewal of the policy. An insurer is not required to reevaluate a policyholder's score pursuant to this paragraph more than twice in any given calendar year.

(f) Insurers must upon request of the applicant or policyholder provide reasonable underwriting exceptions based upon prior credit histories for persons whose credit information is unduly influenced by expenses related to a catastrophic injury or illness, temporary loss of employment, or the death of an immediate family member. The insurer may require reasonable documentation of these events prior to granting an exception.

(g) A credit scoring or insurance scoring methodology must not be used by an insurer if the credit scoring or insurance scoring methodology incorporates the gender, race, nationality, or religion of an insured or applicant.

(h) Insurers that employ a credit scoring or insurance scoring system in underwriting of coverage described in paragraph (a) must have on file with the commissioner:

(1) the insurer's credit scoring or insurance scoring methodology; and

(2) information that supports the insurer's use of a credit score or insurance score as an underwriting criterion.

(i) Insurers described in paragraph (g) shall file the required information with the commissioner within 120 days of August 1, 2002, or prior to implementation of a credit scoring or insurance scoring system by the insurer, if that date is later.

(j) Information provided by, or on behalf of, an insurer to the commissioner under this subdivision is trade secret information under section 13.37.

[For text of subd 37, see M.S.2004]

Subd. 38. **Unfair claims service; service contracts.** No person shall, in connection with a service contract regulated under chapter 59B:

(1) attempt to settle claims on the basis of an application or any other material document which was altered without notice to, or knowledge or consent of, the service contract holder;

(2) make a material misrepresentation to the service contract holder for the purpose and with the intent of effecting settlement of the claims, loss, or damage under the contract on less favorable terms than those provided in, and contemplated by, the contract; or

(3) commit or perform with such frequency as to indicate a general business practice any of the following practices:

(i) failure to properly investigate claims;

(ii) misrepresentation of pertinent facts or contract provisions relating to coverages at issue;

(iii) failure to acknowledge and act upon communications within a reasonable time with respect to claims;

(iv) denial of claims without conducting reasonable investigations based upon available information;

(v) failure to affirm or deny coverage of claims upon written request of the service contract holder within a reasonable time after proof-of-loss statements have been completed; or

(vi) failure to timely provide a reasonable explanation to the service contract holder of the basis in the contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

History: *2005 c 132 s 22,23; 1Sp2005 c 1 art 5 s 12*

72A.201 REGULATION OF CLAIMS PRACTICES.

[For text of subds 1 to 3, see M.S.2004]

Subd. 4. **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)(i) unless provided otherwise by clause (ii) or (iii), other 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;

(ii) for claims submitted under a health policy, the insurer must comply with all of the requirements of section 62Q.75;

(iii) for claims submitted under a health policy that are accepted, the insurer must notify the insured or claimant no less than semiannually of the disposition of claims of the insured or claimant. For purposes of this clause, acceptance of a claim means that there is no additional financial liability for the insured or claimant, either because there is a flat co-payment amount specified in the health plan or because there is no co-payment, deductible, or coinsurance owed;

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

(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.

[For text of subds 4a and 5, see M.S.2004]

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. An insured is not bound by any settlement of its insurer's subrogation claim with respect to the deductible amount, unless the insured receives, as a result of the subrogation settlement, the full amount of the deductible. Recovery by the insurer and receipt by the insured of less than all of the insured's deductible amount does not affect the insured's rights to recover any unreimbursed portion of the deductible from parties liable for the loss;

(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 or engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular contractor or repair shop. Consumer benefits included within preferred vendor programs must not be considered an

incentive or inducement. At the time a claim is reported, the insurer must provide the following advisory to the insured or claimant:

"Minnesota law gives you the right to choose a repair shop to fix your vehicle. Your policy will cover the reasonable costs of repairing your vehicle to its pre-accident condition no matter where you have repairs made. Have you selected a repair shop or would you like a referral?"

After an insured has indicated that the insured has selected a repair shop, the insurer must cease all efforts to influence the insured's or claimant's choice of repair shop;

(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 provide payment to the insured's chosen vendor based on a competitive price that is fair and reasonable within the local industry at large.

Where facts establish that a different rate in a specific geographic area actually served by the vendor is required by that market, that geographic area must be considered. 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, provided, however, that before recommending a vendor, the insurer shall offer its insured the opportunity to choose the vendor. If the insurer recommends a vendor, the insurer must also provide the following advisory:

"Minnesota law gives you the right to go to any glass vendor you choose, and prohibits me from pressuring you to choose a particular vendor.";

(15) requiring that the repair or replacement of motor vehicle glass and related products and services be made in a particular place or shop or by a particular entity, or by otherwise limiting the ability of the insured to select the place, shop, or entity to repair or replace the motor vehicle glass and related products and services; or

(16) engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular company or location to provide the motor vehicle glass repair or replacement services or products. For purposes of this section, a warranty shall not be considered an inducement or incentive.

[For text of subds 7 to 13, see M.S.2004]

History: *2005 c 77 s 5; 2005 c 140 s 1*

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 or privileged 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.

If the insurer, insurance-support organization, or insurance agent determines to disclose or collect a kind of information not specified in a previous authorization, a new authorization specifying that kind of information must be obtained.

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 is valid as long as the individual is continually insured with the insurer. At each renewal of the policy, the insurer must notify the insured in writing of the contents of the authorization and that the authorization remains in effect unless revoked.

(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 is valid as long as the individual is continually insured with the insurer. At each renewal of the policy, the insurer must notify the insured in writing of the contents of the authorization and that the authorization remains in effect unless revoked.

(c) This section and section 72A.502, subdivisions 1 and 12, do not apply to the collection and use of a numeric product referred to as an insurance score or credit score that is used by a licensed insurance agent or insurer exclusively for the purpose of underwriting or rating an insurance policy, if the agent or insurer informs the policyholder or prospective policyholder requesting the insurance coverage that an insurance score or credit score will be obtained for the purpose of underwriting or rating the policy.

[For text of subds 3 and 4, see M.S.2004]

History: *2005 c 74 s 11,12*