1.1 A bill for an act
1.2 relating to commerce; regulating various licenses, forms, certificates, coverages,
1.3 claims practices, disclosures, notices, marketing practices, and records;
1.4 classifying certain data; regulating real estate brokers and appraisers; regulating
1.5 various insurance entities and products, including health, homeowners, motor
1.6 vehicle insurance, and workers' compensation self-insurance; regulating security
1.7 broker-dealers; regulating warranty contracts; regulating mortgage originators;
1.8 sunsetting certain state regulation of telephone solicitations; regulating the use of
1.9 prerecorded or synthesized voice messages; regulating debt management and debt
1.10 settlement services providers; delaying regulating business screening services;
1.11 permitting a deceased professional's surviving spouse to retain ownership of a
1.12 professional firm under certain circumstances; amending Minnesota Statutes
1.13 2008, sections 13.3215; 13.716, by adding a subdivision; 45.011, subdivision
1.14 1; 45.0135, subdivision 7; 58.02, subdivision 17; 59B.01; 60A.08, by adding
1.15 a subdivision; 60A.198, subdivisions 1, 3; 60A.201, subdivision 3; 60A.205,
1.16 subdivision 1; 60A.2085, subdivisions 1, 3, 7, 8; 60A.23, subdivision 8;
1.17 60A.235; 60A.32; 60K.46, by adding a subdivision; 62A.011, subdivision 3;
1.18 62A.136; 62A.17, by adding a subdivision; 62A.3099, subdivision 18; 62A.31,
1.19 subdivision 1, by adding a subdivision; 62A.315; 62A.316; 62L.02, subdivision
1.20 26; 62M.05, subdivision 3a; 65A.27, subdivision 1; 65A.29, by adding a
1.21 subdivision; 65B.133, subdivisions 2, 3, 4; 65B.54, subdivision 1; 67A.191,
1.22 subdivision 2; 72A.20, subdivisions 15, 26; 72A.201, by adding a subdivision;
1.23 79A.04, subdivision 1, by adding a subdivision; 79A.06, by adding a subdivision;
1.24 79A.24, subdivision 1, by adding a subdivision; 82.31, subdivision 4; 82B.08, by
1.25 adding a subdivision; 82B.20, subdivision 2; 319B.02, by adding a subdivision;
1.26 319B.07, subdivision 1; 319B.08; 319B.09, subdivision 1; 325E.27; 332A.02,
1.27 subdivision 13, as amended; 332A.14, as amended; 332B.02, subdivision 13, as
1.28 added; 332B.03, as added; 332B.06, as added; 332B.09, as added; Laws 2008,
1.29 chapter 315, section 19; proposing coding for new law in Minnesota Statutes,
1.30 chapters 60A; 62A; 72A; 80A; 82B; 325E; repealing Minnesota Statutes 2008,
1.31 sections 60A.201, subdivision 4; 70A.07; 79.56, subdivision 4.

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

ARTICLE 1
REGULATION OF COMMERCE

Section 1. Minnesota Statutes 2008, section 45.011, subdivision 1, is amended to read:

Subdivision 1. **Scope.** As used in chapters 45 to 83, 155A, 332, 332A, 345, and 359, and sections 123A.21, subdivision 7, paragraph (a), clause (23); 123A.25; 325D.30 to 325D.42~~,~~; 326B.802 to 326B.885~~, and~~; 386.61 to 386.78~~,~~; 471.617; and 471.982, unless the context indicates otherwise, the terms defined in this section have the meanings given them.

Sec. 2. Minnesota Statutes 2008, section 45.0135, subdivision 7, is amended to read:

Subd. 7. **Assessment.** Each insurer authorized to sell insurance in the state of Minnesota, including surplus lines carriers, and having Minnesota earned premium the previous calendar year shall remit an assessment to the commissioner for deposit in the insurance fraud prevention account on or before June 1 of each year. The amount of the assessment shall be based on the insurer's total assets and on the insurer's total written Minnesota premium, for the preceding fiscal year, as reported pursuant to section 60A.13. The assessment is calculated ~~as follows~~ to be an amount up to the following:

Total Assets	Assessment
Less than $100,000,000	$ 200
$100,000,000 to $1,000,000,000	$ 750
Over $1,000,000,000	$ 2,000

Minnesota Written Premium	Assessment
Less than $10,000,000	$ 200
$10,000,000 to $100,000,000	$ 750
Over $100,000,000	$ 2,000

For purposes of this subdivision, the following entities are not considered to be insurers authorized to sell insurance in the state of Minnesota: risk retention groups; or township mutuals organized under chapter 67A.

EFFECTIVE DATE. This section is effective January 1, 2010.

Sec. 3. Minnesota Statutes 2008, section 58.02, subdivision 17, is amended to read:

Subd. 17. **Person in control.** "Person in control" means any member of senior management, including owners or officers, and other persons who possess, directly or indirectly, the power to direct or cause the direction of the management policies of an applicant or licensee under this chapter, regardless of whether the person has any

3.1 ownership interest in the applicant or licensee. Control is presumed to exist if a person,
3.2 directly or indirectly, owns, controls, or holds with power to vote ten percent or more of
3.3 the voting stock of an applicant or licensee or of a person who owns, controls, or holds
3.4 with power to vote ten percent or more of the voting stock of an applicant or licensee.

3.5 Sec. 4. Minnesota Statutes 2008, section 59B.01, is amended to read:

3.6 **59B.01 SCOPE AND PURPOSE.**

3.7 (a) The purpose of this chapter is to create a legal framework within which service
3.8 contracts may be sold in this state.

3.9 (b) The following are exempt from this chapter:

3.10 (1) warranties;

3.11 (2) maintenance agreements;

3.12 (3) warranties, service contracts, or maintenance agreements offered by public
3.13 utilities, as defined in section 216B.02, subdivision 4, or an entity or operating unit owned
3.14 by or under common control with a public utility;

3.15 (4) service contracts sold or offered for sale to persons other than consumers;

3.16 (5) service contracts on tangible property where the tangible property for which the
3.17 service contract is sold has a purchase price of $250 or less, exclusive of sales tax;

3.18 (6) service contracts for home security equipment installed by a licensed technology
3.19 systems contractor; and

3.20 (7) motor club membership contracts that typically provide roadside assistance
3.21 services to motorists stranded for reasons that include, but are not limited to, mechanical
3.22 breakdown or adverse road conditions.

3.23 (c) The types of agreements referred to in paragraph (b) are not subject to chapters
3.24 60A to 79A, except as otherwise specifically provided by law.

3.25 (d) Service contracts issued by motor vehicle manufacturers covering private
3.26 passenger automobiles are only subject to sections 59B.03, subdivision 5, 59B.05, and
3.27 59B.07.

3.28 (e) All warranty service contracts are deemed to be made in Minnesota for the
3.29 purpose of arbitration.

3.30 Sec. 5. Minnesota Statutes 2008, section 60A.08, is amended by adding a subdivision
3.31 to read:

3.32 Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related
3.33 information filed with the commissioner under section 61A.02 shall be nonpublic data
3.34 until the filing becomes effective.

4.1 (b) All forms, rates, and related information filed with the commissioner under
4.2 section 62A.02 shall be nonpublic data until the filing becomes effective.
4.3 (c) All forms, rates, and related information filed with the commissioner under
4.4 section 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.
4.5 (d) All forms, rates, and related information filed with the commissioner under
4.6 section 70A.06 shall be nonpublic data until the filing becomes effective.
4.7 (e) All forms, rates, and related information filed with the commissioner under
4.8 section 79.56 shall be nonpublic data until the filing becomes effective.

4.9 Sec. 6. **[60A.1755] AGENT ERRORS AND OMISSIONS INSURANCE; CHOICE**
4.10 **OF SOURCE.**
4.11 An insurance company shall not require an insurance agent to maintain insurance
4.12 coverage for the agent's errors and omissions from a specific insurance company. This
4.13 section does not apply if the insurance producer is a captive producer or employee of the
4.14 insurance company imposing the requirement, or if that insurance company or affiliated
4.15 broker-dealer pays for or contributes to the premiums for the errors and omissions
4.16 coverage. For purposes of this section, "captive producer" means a producer that writes
4.17 80 percent or more of the producer's gross annual insurance business for that insurance
4.18 company or any or all of its subsidiaries. Nothing in this section shall prohibit an insurance
4.19 company from requiring an insurance producer to maintain errors and omissions coverage
4.20 or requiring that errors and omissions coverage meet certain criteria.

4.21 Sec. 7. Minnesota Statutes 2008, section 60A.198, subdivision 1, is amended to read:
4.22 Subdivision 1. **License required.** A person, as defined in section 60A.02,
4.23 subdivision 7, shall not act in any other manner as an agent or broker in the transaction
4.24 of surplus lines insurance unless licensed under sections 60A.195 to 60A.209. A surplus
4.25 lines license is not required for a licensed ~~resident~~ agent who assists in the ~~procurement~~
4.26 placement of surplus lines insurance with a surplus lines licensee pursuant to sections
4.27 60A.195 to 60A.209.

4.28 Sec. 8. Minnesota Statutes 2008, section 60A.198, subdivision 3, is amended to read:
4.29 Subd. 3. **Procedure for obtaining license.** A person licensed as an agent in this
4.30 state pursuant to other law may obtain a surplus lines license by doing the following:
4.31 (a) filing an application in the form and with the information the commissioner
4.32 may reasonably require to determine the ability of the applicant to act in accordance
4.33 with sections 60A.195 to 60A.209;

5.1 (b) maintaining an agent's license in this state;
5.2 (c) registering with the association created pursuant to section 60A.2085;
5.3 ~~(c)~~ (d) agreeing to file with the commissioner of revenue all returns required by
5.4 chapter 297I and paying to the commissioner of revenue all amounts required under
5.5 chapter 297I; ~~and~~
5.6 (e) agreeing to file all documents required pursuant to section 60A.2086 and to pay
5.7 the stamping fee assessed pursuant to section 60A.2085, subdivision 7; and
5.8 ~~(d)~~ (f) paying a fee as prescribed by section 60K.55.

5.9 Sec. 9. Minnesota Statutes 2008, section 60A.201, subdivision 3, is amended to read:
5.10 Subd. 3. **Unavailability of other coverage; presumption.** There shall be a
5.11 rebuttable presumption that the following coverages are unavailable from a licensed
5.12 insurer:
5.13 (a) ~~coverages on a list of unavailable coverages maintained by the commissioner~~
5.14 ~~pursuant to subdivision 4;~~
5.15 ~~(b)~~ coverages where one portion of the risk is acceptable to licensed insurers but
5.16 another portion of the same risk is not acceptable. The entire coverage may be placed with
5.17 eligible surplus lines insurers if it can be shown that the eligible surplus lines insurer will
5.18 accept the entire coverage but not the rejected portion alone; and
5.19 ~~(c)~~ (b) any coverage that the licensee is unable to procure after diligent search
5.20 among licensed insurers.

5.21 Sec. 10. Minnesota Statutes 2008, section 60A.205, subdivision 1, is amended to read:
5.22 Subdivision 1. **Authorization.** A surplus lines licensee may be compensated by
5.23 an eligible surplus lines insurer and the licensee may compensate a licensed ~~resident~~
5.24 agent in this state for obtaining surplus lines insurance business. A licensed ~~resident~~
5.25 agent authorized by the licensee may collect a premium on behalf of the licensee, and as
5.26 between the insured and the licensee, the licensee shall be considered to have received the
5.27 premium if the premium payment has been made to the agent.

5.28 Sec. 11. Minnesota Statutes 2008, section 60A.2085, subdivision 1, is amended to read:
5.29 Subdivision 1. **Association created; duties.** There is hereby created a nonprofit
5.30 association to be known as the Surplus Lines Association of Minnesota. The association
5.31 is not a state agency for purposes of chapter 16A, 16B, 16C, or 43A. All surplus lines
5.32 licensees are members of this association. Section 60A.208~~, subdivision 5,~~ does not apply
5.33 to the association created pursuant to the provisions of this section. The association shall

6.1 perform its functions under the plan of operation established under subdivision 3 and must
6.2 exercise its powers through a board of directors established under subdivision 2 as set
6.3 forth in the plan of operation. The association shall be authorized and have the duty to:
6.4 (1) receive, record, and stamp all surplus lines insurance documents that surplus
6.5 lines licensees are required to file with the association;
6.6 (2) prepare and deliver monthly to the commissioners of revenue and commerce a
6.7 report regarding surplus lines business. The report must include a list of all the business
6.8 procured during the preceding month, in the form the commissioners prescribe;
6.9 (3) educate its members regarding the surplus lines law of this state including
6.10 insurance tax responsibilities and the rules and regulations of the commissioners of
6.11 revenue and commerce relative to surplus lines insurance;
6.12 (4) communicate with organizations of agents, brokers, and admitted insurers with
6.13 respect to the proper use of the surplus lines market;
6.14 (5) employ and retain persons necessary to carry out the duties of the association;
6.15 (6) borrow money necessary to effect the purposes of the association and grant a
6.16 security interest or mortgage in its assets, including the stamping fees charged pursuant to
6.17 subdivision 7 in order to secure the repayment of any such borrowed money;
6.18 (7) enter contracts necessary to effect the purposes of the association;
6.19 (8) provide other services to its members that are incidental or related to the
6.20 purposes of the association; ~~and~~
6.21 (9) form and organize itself as a nonprofit corporation under chapter 317A, with the
6.22 powers set forth in section 317A.161 that are not otherwise limited by this section or in
6.23 its articles, bylaws, or plan of operation;
6.24 (10) file such applications and take such other action as necessary to establish and
6.25 maintain the association as tax exempt pursuant to the federal income tax code;
6.26 (11) recommend to the commissioner of commerce revisions to Minnesota law
6.27 relating to the regulation of surplus lines insurance in order to improve the efficiency
6.28 and effectiveness of that regulation; and
6.29 ~~(9)~~ (12) take other actions reasonably required to implement the provisions of this
6.30 section.

6.31 Sec. 12. Minnesota Statutes 2008, section 60A.2085, subdivision 3, is amended to read:
6.32 Subd. 3. **Plan of operation.** (a) The plan of operation shall provide for the
6.33 formation, operation, and governance of the association as a nonprofit corporation
6.34 under chapter 317A. The plan of operation must provide for the election of a board of
6.35 directors by the members of the association. The board of directors shall elect officers as

7.1 provided for in the plan of operation. The plan of operation shall establish the manner of
7.2 voting and may weigh each member's vote to reflect the annual surplus lines insurance
7.3 premium written by the member. Members employed by the same or affiliated employers
7.4 may consolidate their premiums written and delegate an individual officer or partner
7.5 to represent the member in the exercise of association affairs, including service on the
7.6 board of directors.

7.7 (b) The plan of operation shall provide for an independent audit once each year of all
7.8 the books and records of the association and a report of such independent audit shall be
7.9 made to the board of directors, the commissioner of revenue, and the commissioner of
7.10 commerce, with a copy made available to each member to review at the association office.

7.11 (c) The plan of operation and any amendments to the plan of operation shall be
7.12 submitted to the commissioner and shall be effective upon approval in writing by the
7.13 commissioner. The association and all members shall comply with the plan of operation or
7.14 any amendments to it. Failure to comply with the plan of operation or any amendments
7.15 shall constitute a violation for which the commissioner may issue an order requiring
7.16 discontinuance of the violation.

7.17 (d) If the interim board of directors fails to submit a suitable plan of operation
7.18 within 60 days following the creation of the interim board, or if at any time thereafter the
7.19 association fails to submit required amendments to the plan, the commissioner may submit
7.20 to the association a plan of operation or amendments to the plan, which the association
7.21 must follow. The plan of operation or amendments submitted by the commissioner shall
7.22 continue in force until amended by the commissioner or superseded by a plan of operation
7.23 or amendment submitted by the association and approved by the commissioner. A plan
7.24 of operation or an amendment submitted by the commissioner constitutes an order of
7.25 the commissioner.

7.26 Sec. 13. Minnesota Statutes 2008, section 60A.2085, subdivision 7, is amended to read:

7.27 Subd. 7. **Stamping fee.** The services performed by the association shall be
7.28 funded by a stamping fee assessed for each premium-bearing document submitted to
7.29 the association. The stamping fee shall be established by the board of directors of the
7.30 association from time to time. The stamping fee shall be paid by the insured to the surplus
7.31 lines licensee and remitted ~~electronically~~ to the association by the surplus lines licensee <u>in</u>
7.32 <u>the manner established by the association</u>.

7.33 Sec. 14. Minnesota Statutes 2008, section 60A.2085, subdivision 8, is amended to read:

8.1 Subd. 8. **Data classification.** Unless otherwise classified by statute, a temporary
8.2 classification under section 13.06, or federal law, information obtained by the
8.3 commissioner from the association is public, except that any data identifying insureds or
8.4 the Social Security number of a licensee or any information derived therefrom is private
8.5 data on individuals or nonpublic data as defined in section 13.02, subdivisions 9 and 12.

8.6 Sec. 15. Minnesota Statutes 2008, section 60A.23, subdivision 8, is amended to read:
8.7 Subd. 8. **Self-insurance or insurance plan administrators who are vendors**
8.8 **of risk management services.** (1) **Scope.** This subdivision applies to any vendor of
8.9 risk management services and to any entity which administers, for compensation, a
8.10 self-insurance or insurance plan. This subdivision does not apply (a) to an insurance
8.11 company authorized to transact insurance in this state, as defined by section 60A.06,
8.12 subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section
8.13 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section
8.14 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for
8.15 its employees' benefits; (e) to an entity which administers a program of health benefits
8.16 established pursuant to a collective bargaining agreement between an employer, or group
8.17 or association of employers, and a union or unions; or (f) to an entity which administers a
8.18 self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance
8.19 to the plan and if the licensed insurer has appointed the entity administering the plan as
8.20 one of its licensed agents within this state.
8.21 (2) **Definitions.** For purposes of this subdivision the following terms have the
8.22 meanings given them.
8.23 (a) "Administering a self-insurance or insurance plan" means (i) processing,
8.24 reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii)
8.25 otherwise providing necessary administrative services in connection with the operation of
8.26 a self-insurance or insurance plan.
8.27 (b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.
8.28 (c) "Entity" means any association, corporation, partnership, sole proprietorship,
8.29 trust, or other business entity engaged in or transacting business in this state.
8.30 (d) "Self-insurance or insurance plan" means a plan for the benefit of employees
8.31 or members of an association providing life, medical or hospital care, accident, sickness
8.32 or disability insurance ~~for the benefit of employees or members of an association~~, or
8.33 pharmacy benefits, or a plan providing liability coverage for any other risk or hazard,
8.34 which is or is not directly insured or provided by a licensed insurer, service plan
8.35 corporation, or health maintenance organization.

9.1 (e) "Vendor of risk management services" means an entity providing for
9.2 compensation actuarial, financial management, accounting, legal or other services for the
9.3 purpose of designing and establishing a self-insurance or insurance plan for an employer.
9.4 (3) **License.** No vendor of risk management services or entity administering a
9.5 self-insurance or insurance plan may transact this business in this state unless it is licensed
9.6 to do so by the commissioner. An applicant for a license shall state in writing the type of
9.7 activities it seeks authorization to engage in and the type of services it seeks authorization
9.8 to provide. The license may be granted only when the commissioner is satisfied that the
9.9 entity possesses the necessary organization, background, expertise, and financial integrity
9.10 to supply the services sought to be offered. The commissioner may issue a license subject
9.11 to restrictions or limitations upon the authorization, including the type of services which
9.12 may be supplied or the activities which may be engaged in. The license fee is $1,500
9.13 for the initial application and $1,500 for each three-year renewal. All licenses are for
9.14 a period of three years.
9.15 (4) **Regulatory restrictions; powers of the commissioner.** To assure that
9.16 self-insurance or insurance plans are financially solvent, are administered in a fair and
9.17 equitable fashion, and are processing claims and paying benefits in a prompt, fair,
9.18 and honest manner, vendors of risk management services and entities administering
9.19 insurance or self-insurance plans are subject to the supervision and examination by the
9.20 commissioner. Vendors of risk management services, entities administering insurance or
9.21 self-insurance plans, and insurance or self-insurance plans established or operated by
9.22 them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu
9.23 of an unlimited guarantee from a parent corporation for a vendor of risk management
9.24 services or an entity administering insurance or self-insurance plans, the commissioner
9.25 may accept a surety bond in a form satisfactory to the commissioner in an amount equal to
9.26 120 percent of the total amount of claims handled by the applicant in the prior year. If at
9.27 any time the total amount of claims handled during a year exceeds the amount upon which
9.28 the bond was calculated, the administrator shall immediately notify the commissioner.
9.29 The commissioner may require that the bond be increased accordingly.
9.30 No contract entered into after July 1, 2001, between a licensed vendor of risk
9.31 management services and a group authorized to self-insure for workers' compensation
9.32 liabilities under section 79A.03, subdivision 6, may take effect until it has been filed
9.33 with the commissioner, and either (1) the commissioner has approved it or (2) 60 days
9.34 have elapsed and the commissioner has not disapproved it as misleading or violative of
9.35 public policy.

10.1 (5) **Rulemaking authority.** To carry out the purposes of this subdivision, the
10.2 commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:
10.3 (a) establish reporting requirements for administrators of insurance or self-insurance
10.4 plans;
10.5 (b) establish standards and guidelines to assure the adequacy of financing, reinsuring,
10.6 and administration of insurance or self-insurance plans;
10.7 (c) establish bonding requirements or other provisions assuring the financial integrity
10.8 of entities administering insurance or self-insurance plans; or
10.9 (d) establish other reasonable requirements to further the purposes of this
10.10 subdivision.

10.11 Sec. 16. Minnesota Statutes 2008, section 60A.235, is amended to read:

10.12 **60A.235 STANDARDS FOR DETERMINING WHETHER CONTRACTS**
10.13 **ARE HEALTH PLAN CONTRACTS OR STOP LOSS CONTRACTS.**

10.14 Subdivision 1. **Findings and purpose.** The purpose of this section is to establish
10.15 a standard for the determination of whether an insurance policy or other evidence or
10.16 coverage should be treated as a policy of accident and sickness insurance or a stop loss
10.17 policy for the purpose of the regulation of the business of insurance. The laws regulating
10.18 the business of insurance in Minnesota impose distinctly different requirements upon
10.19 accident and sickness insurance policies and stop loss policies. In particular, the regulation
10.20 of accident and sickness insurance in Minnesota includes measures designed to reform the
10.21 health insurance market, to minimize or prohibit selective rating or rejection of employee
10.22 groups or individual group members based upon health conditions, and to provide access
10.23 to affordable health insurance coverage regardless of preexisting health conditions. The
10.24 health care reform provisions enacted in Minnesota will only be effective if they are
10.25 applied to all insurers and health carriers who in substance, regardless of purported form,
10.26 engage in the business of issuing health insurance coverage to employees of an employee
10.27 group. This section applies to insurance companies and health carriers and the policies or
10.28 other evidence of coverage that they issue. This section does not apply to employers or the
10.29 benefit plans they establish for their employees.

10.30 Subd. 2. **Definitions.** For purposes of this section, the terms defined in this
10.31 subdivision have the meanings given.
10.32 (a) "Attachment point" means the claims amount incurred by an insured group
10.33 beyond which the insurance company or health carrier incurs a liability for payment.
10.34 (b) "Direct coverage" means coverage under which an insurance company or health
10.35 carrier assumes a direct obligation to an individual, under the policy or evidence of

coverage, with respect to health care expenses incurred by the individual or a member of the individual's family.

(c) "Expected claims" means the amount of claims that, in the absence of a stop loss policy or other insurance or evidence of coverage, are projected to be incurred ~~under~~ by an employer-sponsored plan covering health care expenses.

(d) "Expected plan claims" means the expected claims less the projected claims in excess of the specific attachment point, adjusted to be consistent with the employer's aggregate contract period.

(e) "Health plan" means a health plan as defined in section 62A.011 and includes group coverage regardless of the size of the group.

(f) "Health carrier" means a health carrier as defined in section 62A.011.

Subd. 3. **Health plan policies issued as stop loss coverage.** (a) An insurance company or health carrier issuing or renewing an insurance policy or other evidence of coverage, that provides coverage to an employer for health care expenses incurred under an employer-sponsored plan provided to the employer's employees, retired employees, or their dependents, shall issue the policy or evidence of coverage as a health plan if the policy or evidence of coverage:

(1) has a specific attachment point for claims incurred per individual that is lower than ~~$10,000~~ $20,000; or

(2) has an aggregate attachment point, for groups of 50 or fewer, that is lower than the ~~sum~~ greater of:

~~(i) 140 percent of the first $50,000 of expected plan claims;~~

~~(ii) 120 percent of the next $450,000 of expected plan claims; and~~

~~(iii) 110 percent of the remaining expected plan claims.~~

(i) $4,000 times the number of group members;

(ii) 120 percent of expected claims; or

(iii) $20,000; or

(3) has an aggregate attachment point for groups of 51 or more that is lower than 110 percent of expected claims.

(b) An insurer shall determine the number of persons in a group, for the purposes of this section, on a consistent basis, at least annually. Where the insurance policy or evidence of coverage applies to a contract period of more than one year, the dollar amounts set forth in paragraph (a), clauses (1) and (2), must be multiplied by the length of the contract period expressed in years.

(c) The commissioner may adjust the constant dollar amounts provided in paragraph (a), clauses (1) ~~and~~, (2), and (3), on January 1 of any year, based upon changes in

12.1 the medical component of the Consumer Price Index (CPI). Adjustments must be in
12.2 increments of $100 and must not be made unless at least that amount of adjustment is
12.3 required. The commissioner shall publish any change in these dollar amounts at least
12.4 ~~three~~ six months before their effective date.

12.5 (d) A policy or evidence of coverage issued by an insurance company or health
12.6 carrier that provides direct coverage of health care expenses of an individual including a
12.7 policy or evidence of coverage administered on a group basis is a health plan regardless of
12.8 whether the policy or evidence of coverage is denominated as stop loss coverage.

12.9 Subd. 3a. **Actuarial certification.** An insurer shall file with the commissioner
12.10 annually on or before March 15, an actuarial certification certifying that the insurer is in
12.11 compliance with sections 60A.235 and 60A.236. The certification shall be in a form and
12.12 manner, and shall contain information, specified by the commissioner. A copy of the
12.13 certification shall be retained by the insurer at its principal place of business.

12.14 Subd. 4. **Compliance.** (a) An insurance company or health carrier that is required to
12.15 issue a policy or evidence of coverage as a health plan under this section shall, even if the
12.16 policy or evidence of coverage is denominated as stop loss coverage, comply with all the
12.17 laws of this state that apply to the health plan, including, but not limited to, chapters 62A,
12.18 62C, 62D, 62E, 62L, and 62Q.

12.19 (b) With respect to an employer who had been issued a policy or evidence of
12.20 coverage denominated as stop loss coverage before ~~June 2, 1995~~ the effective date of this
12.21 section, compliance with this section is required as of the first renewal date occurring on
12.22 or after ~~June 2, 1995~~ August 1, 2009, and applies to policies issued or renewed on or
12.23 after that date.

12.24 Sec. 17. Minnesota Statutes 2008, section 60A.32, is amended to read:

12.25 **60A.32 RATE FILING FOR CROP HAIL INSURANCE.**

12.26 Subdivision 1. **Authority.** An insurer issuing policies of insurance against crop
12.27 damage by hail in this state shall file its insurance rates with the commissioner using the
12.28 expedited filing procedure under subdivision 2. The insurance rates must be filed before
12.29 February 1 of the year in which a policy is issued.

12.30 Subd. 2. **Compliance certifications.** In addition to the proposed rates, an insurer
12.31 shall file with the Department of Commerce on a form prescribed by the commissioner a
12.32 written certification, signed by an officer of the insurer, that the rates comply with section
12.33 70A.04. Rates filed under this procedure are effective upon the date of receipt or on a
12.34 subsequent date requested by the insurer.

13.1 Subd. 3. **Fee.** In order to be effective, the filing must be accompanied by payment of
13.2 the applicable filing fee.

13.3 Sec. 18. **[60A.39] CERTIFICATES OF INSURANCE.**
13.4 Subdivision 1. **Issuance.** A licensed insurer or insurance producer may provide to a
13.5 third party a certificate of insurance which documents insurance coverage. The purpose
13.6 of a certificate of insurance is to provide evidence of insurance coverage and the amount
13.7 of insurance issued.
13.8 Subd. 2. **Approval.** An insurer or licensed producer shall not issue a certificate of
13.9 insurance or other document or instrument that either affirmatively or negatively amends,
13.10 extends, or alters the coverage provided by an approved policy, form, or endorsement
13.11 without the written approval of the commissioner.
13.12 Subd. 3. **Required statement.** A certificate or memorandum of property or casualty
13.13 insurance when issued to any person other than the policyholder must contain the following
13.14 or similar statement: "This certificate or memorandum of insurance does not affirmatively
13.15 or negatively amend, extend, or alter the coverage afforded by the insurance policy."
13.16 Subd. 4. **Cancellation notice.** A certificate provided to a third party must not
13.17 provide for notice of cancellation that exceeds the statutory notice of cancellation provided
13.18 to the policyholder.
13.19 Subd. 5. **Filing.** An insurer not using the standard ACORD or ISO form "Certificate
13.20 of Insurance" shall file with the commissioner, prior to its use, the form of certificate or
13.21 memorandum of insurance coverage that will be used by the insurer. Filed forms may not
13.22 be amended at the request of a third party.
13.23 Subd. 6. **Opinion letters.** A licensed insurance producer may not issue, in lieu of a
13.24 certificate, an agent's opinion letter or other correspondence that is inconsistent with
13.25 this section.

13.26 Sec. 19. Minnesota Statutes 2008, section 60K.46, is amended by adding a subdivision
13.27 to read:
13.28 Subd. 8. **Certificates of insurance.** An insurance producer shall not issue a
13.29 certificate of insurance, or other evidence of insurance coverage that either affirmatively or
13.30 negatively amends, extends, or alters the coverage as provided by the policy, or provides
13.31 notice of cancellation to a third party that exceeds the statutory notice requirement to a
13.32 policyholder.

13.33 Sec. 20. Minnesota Statutes 2008, section 62A.011, subdivision 3, is amended to read:

14.1 Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and
14.2 sickness insurance as defined in section 62A.01 offered by an insurance company licensed
14.3 under chapter 60A; a subscriber contract or certificate offered by a nonprofit health
14.4 service plan corporation operating under chapter 62C; a health maintenance contract or
14.5 certificate offered by a health maintenance organization operating under chapter 62D; a
14.6 health benefit certificate offered by a fraternal benefit society operating under chapter
14.7 64B; or health coverage offered by a joint self-insurance employee health plan operating
14.8 under chapter 62H. Health plan means individual and group coverage, unless otherwise
14.9 specified. Health plan does not include coverage that is:
14.10 (1) limited to disability or income protection coverage;
14.11 (2) automobile medical payment coverage;
14.12 (3) supplemental to liability insurance;
14.13 (4) designed solely to provide payments on a per diem, fixed indemnity, or
14.14 non-expense-incurred basis;
14.15 (5) credit accident and health insurance as defined in section 62B.02;
14.16 (6) designed solely to provide hearing, dental, or vision care;
14.17 (7) blanket accident and sickness insurance as defined in section 62A.11;
14.18 (8) accident-only coverage;
14.19 (9) a long-term care policy as defined in section 62A.46 or 62S.01;
14.20 (10) issued as a supplement to Medicare, as defined in sections 62A.3099 to
14.21 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health
14.22 maintenance organizations or those policies, contracts, or certificates governed by section
14.23 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section
14.24 1395, et seq., as amended;
14.25 (11) workers' compensation insurance; or
14.26 (12) issued solely as a companion to a health maintenance contract as described in
14.27 section 62D.12, subdivision 1a, so long as the health maintenance contract meets the
14.28 definition of a health plan.

14.29 Sec. 21. Minnesota Statutes 2008, section 62A.136, is amended to read:

14.30 **62A.136 HEARING, DENTAL, AND VISION PLAN COVERAGE.**

14.31 The following provisions do not apply to health plans as defined in section 62A.011,
14.32 subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections
14.33 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17,
14.34 subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304;
14.35 62A.3093; and 62E.16.

15.1 Sec. 22. Minnesota Statutes 2008, section 62A.17, is amended by adding a subdivision
15.2 to read:

15.3 Subd. 5b. **Notices required by the American Recovery and Reinvestment Act of**
15.4 **2009 (ARRA).** (a) An employer that maintains a group health plan that is not described in
15.5 Internal Revenue Code, section 6432(b)(1) or (2), as added by section 3001(a)(12)(A) of
15.6 the American Recovery and Reinvestment Act of 2009 (ARRA), must notify the health
15.7 carrier of the termination of, or the layoff from, employment of a covered employee, and
15.8 the name and last known address of the employee, within the later of ten days after the
15.9 termination or layoff event, or June 8, 2009.

15.10 (b) The health carrier for a group health plan that is not described in Internal Revenue
15.11 Code, section 6432(b)(1) or (2), as added by section 3001(a)(12)(A) of the ARRA,
15.12 must provide the notice of extended election rights which is required by subdivision
15.13 5a, paragraph (a), as well as any other notice that is required by the ARRA regarding
15.14 the availability of premium reduction rights, to the individual within 30 days after the
15.15 employer notifies the health carrier as required by paragraph (a).

15.16 (c) The notice responsibilities set forth in this subdivision end when the premium
15.17 reduction provisions under ARRA expire.

15.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.

15.19 Sec. 23. Minnesota Statutes 2008, section 62A.3099, subdivision 18, is amended to
15.20 read:

15.21 Subd. 18. **Medicare supplement policy or certificate.** "Medicare supplement
15.22 policy or certificate" means a group or individual policy of accident and sickness insurance
15.23 or a subscriber contract of hospital and medical service associations or health maintenance
15.24 organizations, other than those policies or certificates covered by section 1833 of the
15.25 federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued
15.26 policy under a demonstration project specified under amendments to the federal Social
15.27 Security Act, which is advertised, marketed, or designed primarily as a supplement to
15.28 reimbursements under Medicare for the hospital, medical, or surgical expenses of persons
15.29 eligible for Medicare or as a supplement to Medicare Advantage Plans established under
15.30 Medicare Part C. "Medicare supplement policy" does not include Medicare Advantage
15.31 plans established under Medicare Part C, outpatient prescription drug plans established
15.32 under Medicare Part D, or any health care prepayment plan that provides benefits under an
15.33 agreement under section 1833(a)(1)(A) of the Social Security Act.

15.34 Sec. 24. Minnesota Statutes 2008, section 62A.31, subdivision 1, is amended to read:

16.1 Subdivision 1. **Policy requirements.** No individual or group policy, certificate,
16.2 subscriber contract issued by a health service plan corporation regulated under chapter
16.3 62C, or other evidence of accident and health insurance the effect or purpose of which
16.4 is to supplement Medicare coverage, including to supplement coverage under Medicare
16.5 Advantage Plans established under Medicare Part C, issued or delivered in this state
16.6 or offered to a resident of this state shall be sold or issued to an individual covered by
16.7 Medicare unless the requirements in subdivisions 1a to 1u are met.

16.8 Sec. 25. Minnesota Statutes 2008, section 62A.31, is amended by adding a subdivision
16.9 to read:
16.10 Subd. 8. **Prohibition against use of genetic information and requests for genetic**
16.11 **information.** This subdivision applies to all policies with policy years beginning on or
16.12 after May 21, 2009.
16.13 (a) An issuer of a Medicare supplement policy or certificate:
16.14 (1) shall not deny or condition the issuance or effectiveness of the policy or
16.15 certificate, including the imposition of any exclusion of benefits under the policy based
16.16 on a preexisting condition, on the basis of the genetic information with respect to such
16.17 individual; and
16.18 (2) shall not discriminate in the pricing of the policy or certificate, including the
16.19 adjustment of premium rates, of an individual on the basis of the genetic information
16.20 with respect to such individual.
16.21 (b) Nothing in paragraph (a) shall be construed to limit the ability of an issuer, to the
16.22 extent otherwise permitted by law, from:
16.23 (1) denying or conditioning the issuance or effectiveness of the policy or certificate
16.24 or increasing the premium for a group based on the manifestation of a disease or disorder
16.25 of an insured or applicant; or
16.26 (2) increasing the premium for any policy issued to an individual based on the
16.27 manifestation of a disease or disorder of an individual who is covered under the policy.
16.28 In such case, the manifestation of a disease or disorder in one individual cannot also
16.29 be used as genetic information about other group members and to further increase the
16.30 premium for the group.
16.31 (c) An issuer of a Medicare supplement policy or certificate shall not request or
16.32 require an individual or a family member of such individual to undergo a genetic test.
16.33 (d) Paragraph (c) shall not be construed to preclude an issuer of a Medicare
16.34 supplement policy or certificate from obtaining and using the results of a genetic test in
16.35 making a determination regarding payment, as defined for the purposes of applying the

17.1 regulations promulgated under Part C of title XI and section 264 of the Health Insurance
17.2 Portability and Accountability Act of 1996 as they may be revised from time to time,
17.3 and consistent with paragraph (a).

17.4 (e) For purposes of carrying out paragraph (d), an issuer of a Medicare supplement
17.5 policy or certificate may request only the minimum amount of information necessary to
17.6 accomplish the intended purpose.

17.7 (f) Notwithstanding paragraph (c), an issuer of a Medicare supplement policy may
17.8 request, but not require, that an individual or a family member of such individual undergo
17.9 a genetic test if each of the following conditions are met:

17.10 (1) the request is made pursuant to research that complies with Code of Federal
17.11 Regulations title 45, part 46, or equivalent federal regulations, and any applicable state or
17.12 local law or regulations for the protection of human subjects in research;

17.13 (2) the issuer clearly indicates to each individual, or in the case of a minor child, to
17.14 the legal guardian of such child, to whom the request is made that:

17.15 (i) compliance with the request is voluntary; and

17.16 (ii) noncompliance will have no effect on enrollment status or premium or
17.17 contribution amounts.

17.18 (3) no genetic information collected or acquired under this paragraph shall be used
17.19 for underwriting, determination of eligibility to enroll or maintain enrollment status,
17.20 premium rates, or the issuance, renewal, or replacement of a policy or certificate;

17.21 (4) the issuer notifies the secretary in writing that the issuer is conducting activities
17.22 pursuant to the exception provided for under this paragraph, including a description of the
17.23 activities conducted; and

17.24 (5) the issuer complies with such other conditions as the secretary may by regulation
17.25 require for activities under this paragraph.

17.26 (g) An issuer of a Medicare supplement policy or certificate shall not request,
17.27 require, or purchase genetic information for underwriting purposes.

17.28 (h) An issuer of a Medicare supplement policy or certificate shall not request,
17.29 require, or purchase genetic information with respect to any individual prior to such
17.30 individual's enrollment under the policy in connection with such enrollment.

17.31 (i) An issuer of a Medicare supplement policy or certificate that obtains genetic
17.32 information incidental to the requesting, requiring, or purchasing of other information
17.33 concerning any individual, such request, requirement, or purchase shall not be considered
17.34 a violation of paragraph (h) if such request, requirement, or purchase is not in violation of
17.35 paragraph (g).

17.36 (j) For purposes of this subdivision only:

18.1 (1) "family member" means, with respect to an individual, any other individual who
18.2 is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual;
18.3 (2) "genetic information" means, with respect to any individual, information about
18.4 such individual's genetic tests, the genetic test of family members of such individual,
18.5 and the manifestation of a disease or disorder in family members of such individual.
18.6 Such terms includes, with respect to any individual, any request for, or receipt of, genetic
18.7 services, or participation in clinical research that includes genetic services, by such
18.8 individual or any family member of such individual. Any reference to genetic information
18.9 concerning an individual or family member of an individual who is a pregnant woman,
18.10 includes genetic information of any fetus carried by such pregnant woman, or with respect
18.11 to an individual or family member utilizing reproductive technology, includes genetic
18.12 information of any embryo legally held by an individual or family member. The term
18.13 genetic information does not include information about the sex or age of any individual;
18.14 (3) "genetic services" means a genetic test or genetic counseling, including
18.15 obtaining, interpreting, or assessing genetic information or genetic education;
18.16 (4) "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins,
18.17 or metabolites, that detect genotypes, mutations, or chromosomal changes. The term
18.18 genetic test does not mean an analysis of proteins or metabolites that does not detect
18.19 genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites
18.20 that is directly related to a manifested disease, disorder, or pathological condition that
18.21 could reasonably be detected by a health care professional with appropriate training and
18.22 expertise in the field of medicine involved;
18.23 (5) "issuer of a Medicare supplement policy or certificate" includes a third-party
18.24 administrator or other person acting for or on behalf of such issuer; and
18.25 (6) "underwriting purposes" means:
18.26 (i) rules for, or determination of, eligibility including enrollment and continued
18.27 eligibility, for benefits under the policy;
18.28 (ii) the computation of premium or contribution amounts under the policy;
18.29 (iii) the application of any preexisting condition exclusion under the policy; and
18.30 (iv) other activities related to the creation, renewal, or replacement of a contract of
18.31 health insurance or health benefits.

18.32 Sec. 26. Minnesota Statutes 2008, section 62A.315, is amended to read:

18.33 **62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN;**
18.34 **COVERAGE.**

19.1 The extended basic Medicare supplement plan must have a level of coverage so that
19.2 it will be certified as a qualified plan pursuant to section 62E.07, and will provide:
19.3 (1) coverage for all of the Medicare Part A inpatient hospital deductible and
19.4 coinsurance amounts, and 100 percent of all Medicare Part A eligible expenses for
19.5 hospitalization not covered by Medicare;
19.6 (2) coverage for the daily co-payment amount of Medicare Part A eligible expenses
19.7 for the calendar year incurred for skilled nursing facility care;
19.8 (3) coverage for the coinsurance amount or in the case of hospital outpatient
19.9 department services paid under a prospective payment system, the co-payment amount, of
19.10 Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and
19.11 the Medicare Part B deductible amount;
19.12 (4) 80 percent of the usual and customary hospital and medical expenses and
19.13 supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation
19.14 established by the Medicare program or state law, the usual and customary hospital
19.15 and medical expenses and supplies, described in section 62E.06, subdivision 1, while
19.16 in a foreign country; and prescription drug expenses, not covered by Medicare. An
19.17 outpatient prescription drug benefit must not be included for sale or issuance in a Medicare
19.18 supplement policy or certificate issued on or after January 1, 2006;
19.19 (5) coverage for the reasonable cost of the first three pints of blood, or equivalent
19.20 quantities of packed red blood cells as defined under federal regulations under Medicare
19.21 Parts A and B, unless replaced in accordance with federal regulations;
19.22 (6) 100 percent of the cost of immunizations not otherwise covered under Part
19.23 D of the Medicare program and routine screening procedures for cancer, including
19.24 mammograms and pap smears;
19.25 (7) preventive medical care benefit: coverage for the following preventive health
19.26 services not covered by Medicare:
19.27 (i) an annual clinical preventive medical history and physical examination that may
19.28 include tests and services from clause (ii) and patient education to address preventive
19.29 health care measures;
19.30 (ii) preventive screening tests or preventive services, the selection and frequency of
19.31 which is determined to be medically appropriate by the attending physician.
19.32 Reimbursement shall be for the actual charges up to 100 percent of the
19.33 Medicare-approved amount for each service as if Medicare were to cover the service as
19.34 identified in American Medical Association current procedural terminology (AMA CPT)
19.35 codes to a maximum of $120 annually under this benefit. This benefit shall not include
19.36 payment for any procedure covered by Medicare;

~~(8) at-home recovery benefit: coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:~~

~~(i) for purposes of this benefit, the following definitions shall apply:~~

~~(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;~~

~~(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;~~

~~(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;~~

~~(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;~~

~~(ii) coverage requirements and limitations:~~

~~(A) at-home recovery services provided must be primarily services that assist in activities of daily living;~~

~~(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;~~

~~(C) coverage is limited to:~~

~~(I) no more than the number and type of at-home recovery visits certified as medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;~~

~~(II) the actual charges for each visit up to a maximum reimbursement of $100 per visit;~~

~~(III) $4,000 per calendar year;~~

~~(IV) seven visits in any one week;~~

~~(V) care furnished on a visiting basis in the insured's home;~~

~~(VI) services provided by a care provider as defined in this section;~~

~~(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;~~

21.1 ~~(VIII) at-home recovery visits received during the period the insured is receiving~~
21.2 ~~Medicare-approved home care services or no more than eight weeks after the service date~~
21.3 ~~of the last Medicare-approved home health care visit;~~
21.4 ~~(iii) coverage is excluded for:~~
21.5 ~~(A) home care visits paid for by Medicare or other government programs; and~~
21.6 ~~(B) care provided by unpaid volunteers or providers who are not care providers.~~
21.7 (8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite
21.8 care expenses; and
21.9 (9) coverage for cost sharing for Medicare Part A or B home health care services
21.10 and medical supplies.

21.11 Sec. 27. Minnesota Statutes 2008, section 62A.316, is amended to read:

21.12 **62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

21.13 (a) The basic Medicare supplement plan must have a level of coverage that will
21.14 provide:
21.15 (1) coverage for all of the Medicare Part A inpatient hospital coinsurance amounts,
21.16 and 100 percent of all Medicare part A eligible expenses for hospitalization not covered
21.17 by Medicare, after satisfying the Medicare Part A deductible;
21.18 (2) coverage for the daily co-payment amount of Medicare Part A eligible expenses
21.19 for the calendar year incurred for skilled nursing facility care;
21.20 (3) coverage for the coinsurance amount, or in the case of outpatient department
21.21 services paid under a prospective payment system, the co-payment amount, of Medicare
21.22 eligible expenses under Medicare Part B regardless of hospital confinement, subject to
21.23 the Medicare Part B deductible amount;
21.24 (4) 80 percent of the hospital and medical expenses and supplies incurred during
21.25 travel outside the United States as a result of a medical emergency;
21.26 (5) coverage for the reasonable cost of the first three pints of blood, or equivalent
21.27 quantities of packed red blood cells as defined under federal regulations under Medicare
21.28 Parts A and B, unless replaced in accordance with federal regulations;
21.29 (6) 100 percent of the cost of immunizations not otherwise covered under Part D of
21.30 the Medicare program and routine screening procedures for cancer screening including
21.31 mammograms and pap smears; ~~and~~
21.32 (7) 80 percent of coverage for all physician prescribed medically appropriate and
21.33 necessary equipment and supplies used in the management and treatment of diabetes
21.34 not otherwise covered under Part D of the Medicare program. Coverage must include

persons with gestational, type I, or type II diabetes. Coverage under this clause is subject to section 62A.3093, subdivision 2~~.~~;

(8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses; and

(9) coverage for cost sharing for Medicare Part A or B home health care services and medical supplies subject to the Medicare Part B deductible amount.

(b) ~~Only~~ The following ~~optional~~ benefit riders ~~may be added to~~ must be offered with this plan:

(1) coverage for all of the Medicare Part A inpatient hospital deductible amount;

(2) ~~a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare Part B~~ 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(3) coverage for all of the Medicare Part B annual deductible; and

~~(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006;~~

~~(5)~~ (4) preventive medical care benefit coverage for the following preventative health services not covered by Medicare:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for a procedure covered by Medicare~~;~~.

~~(6) coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:~~

~~(i) For purposes of this benefit, the following definitions apply:~~

23.1 ~~(A) "activities of daily living" include, but are not limited to, bathing, dressing,~~
23.2 ~~personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally~~
23.3 ~~self-administered, and changing bandages or other dressings;~~
23.4 ~~(B) "care provider" means a duly qualified or licensed home health aide/homemaker,~~
23.5 ~~personal care aid, or nurse provided through a licensed home health care agency or~~
23.6 ~~referred by a licensed referral agency or licensed nurses registry;~~
23.7 ~~(C) "home" means a place used by the insured as a place of residence, provided~~
23.8 ~~that the place would qualify as a residence for home health care services covered by~~
23.9 ~~Medicare. A hospital or skilled nursing facility shall not be considered the insured's~~
23.10 ~~place of residence;~~
23.11 ~~(D) "at-home recovery visit" means the period of a visit required to provide at-home~~
23.12 ~~recovery care, without limit on the duration of the visit, except each consecutive four~~
23.13 ~~hours in a 24-hour period of services provided by a care provider is one visit;~~
23.14 ~~(ii) Coverage requirements and limitations:~~
23.15 ~~(A) at-home recovery services provided must be primarily services that assist in~~
23.16 ~~activities of daily living;~~
23.17 ~~(B) the insured's attending physician must certify that the specific type and frequency~~
23.18 ~~of at-home recovery services are necessary because of a condition for which a home care~~
23.19 ~~plan of treatment was approved by Medicare;~~
23.20 ~~(C) coverage is limited to:~~
23.21 ~~(I) no more than the number and type of at-home recovery visits certified as~~
23.22 ~~necessary by the insured's attending physician. The total number of at-home recovery~~
23.23 ~~visits shall not exceed the number of Medicare-approved home care visits under a~~
23.24 ~~Medicare-approved home care plan of treatment;~~
23.25 ~~(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;~~
23.26 ~~(III) $1,600 per calendar year;~~
23.27 ~~(IV) seven visits in any one week;~~
23.28 ~~(V) care furnished on a visiting basis in the insured's home;~~
23.29 ~~(VI) services provided by a care provider as defined in this section;~~
23.30 ~~(VII) at-home recovery visits while the insured is covered under the policy or~~
23.31 ~~certificate and not otherwise excluded;~~
23.32 ~~(VIII) at-home recovery visits received during the period the insured is receiving~~
23.33 ~~Medicare-approved home care services or no more than eight weeks after the service date~~
23.34 ~~of the last Medicare-approved home health care visit;~~
23.35 ~~(iii) Coverage is excluded for:~~
23.36 ~~(A) home care visits paid for by Medicare or other government programs; and~~

24.1 ~~(B) care provided by family members, unpaid volunteers, or providers who are~~
24.2 ~~not care providers;~~
24.3 ~~(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and~~
24.4 ~~customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually~~
24.5 ~~under this benefit. An issuer of Medicare supplement insurance policies that elects to~~
24.6 ~~offer this benefit rider shall also make available coverage that contains the rider specified~~
24.7 ~~in clause (4). An outpatient prescription drug benefit must not be included for sale or~~
24.8 ~~issuance in a Medicare policy or certificate issued on or after January 1, 2006.~~

24.9 Sec. 28. **[62A.3163] MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT**
24.10 **PART A DEDUCTIBLE COVERAGE.**
24.11 The Medicare supplement plan with 50 percent Part A deductible coverage must
24.12 have a level of coverage that will provide:
24.13 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
24.14 365 days after Medicare benefits end;
24.15 (2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible
24.16 amount per benefit period;
24.17 (3) coverage for the coinsurance amount for each day used from the 21st through
24.18 the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible
24.19 under Medicare Part A;
24.20 (4) coverage for cost sharing for all Medicare Part A eligible hospice and respite
24.21 care expenses;
24.22 (5) coverage under Medicare Part A or B for the reasonable cost of the first three
24.23 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal
24.24 regulations;
24.25 (6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare
24.26 Part B, after the policyholder pays the Medicare Part B deductible;
24.27 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
24.28 services and diagnostic procedures for cancer screening described in section 62A.30 after
24.29 the policyholder pays the Medicare Part B deductible;
24.30 (8) coverage of 80 percent of the hospital and medical expenses and supplies
24.31 incurred during travel outside of the United States as a result of a medical emergency; and
24.32 (9) coverage for 100 percent of the Medicare Part A or B home health care services
24.33 and medical supplies after the policyholder pays the Medicare Part B deductible.

25.1 Sec. 29. **[62A.3164] MEDICARE SUPPLEMENT PLAN WITH $20 AND $50**
25.2 **CO-PAYMENT MEDICARE PART B COVERAGE.**

25.3 The Medicare supplement plan with $20 and $50 co-payment Medicare Part B
25.4 coverage must have a level of coverage that will provide:

25.5 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
25.6 365 days after Medicare benefits end;

25.7 (2) coverage for the Medicare Part A inpatient hospital deductible amount per
25.8 benefit period;

25.9 (3) coverage for the coinsurance amount for each day used from the 21st through
25.10 the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible
25.11 under Medicare Part A;

25.12 (4) coverage for the cost sharing for all Medicare Part A eligible hospice and respite
25.13 care expenses;

25.14 (5) coverage for Medicare Part A or B of the reasonable cost of the first three pints
25.15 of blood, or equivalent quantities of packed red blood cells, as defined under federal
25.16 regulations, unless replaced according to federal regulations;

25.17 (6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare
25.18 Part B except for the lesser of $20 or the Medicare Part B coinsurance or co-payment
25.19 for each covered health care provider office visit and the lesser of $50 or the Medicare
25.20 Part B coinsurance or co-payment for each covered emergency room visit; however, this
25.21 co-payment shall be waived if the insured is admitted to any hospital and the emergency
25.22 visit is subsequently covered as a Medicare Part A expense;

25.23 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
25.24 services and diagnostic procedures for cancer screening described in section 62A.30 after
25.25 the policyholder pays the Medicare Part B deductible;

25.26 (8) coverage of 80 percent of the hospital and medical expenses and supplies
25.27 incurred during travel outside of the United States as a result of a medical emergency; and

25.28 (9) coverage for Medicare Part A or B home health care services and medical
25.29 supplies after the policyholder pays the Medicare Part B deductible.

25.30 Sec. 30. **[62A.3165] MEDICARE SUPPLEMENT PLAN WITH HIGH**
25.31 **DEDUCTIBLE COVERAGE.**

25.32 The Medicare supplement plan will pay 100 percent coverage upon payment of the
25.33 annual high deductible. The annual deductible shall consist of out-of-pocket expenses,
25.34 other than premiums, for services covered. This plan must have a level of coverage that
25.35 will provide:

26.1 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
26.2 365 days after Medicare benefits end;
26.3 (2) coverage for 100 percent of the Medicare Part A inpatient hospital deductible
26.4 amount per benefit period;
26.5 (3) coverage for 100 percent of the coinsurance amount for each day used from the
26.6 21st through the 100th day in a Medicare benefit period for post-hospital skilled nursing
26.7 care eligible under Medicare Part A;
26.8 (4) coverage for 100 percent of cost sharing for all Medicare Part A eligible
26.9 expenses and respite care;
26.10 (5) coverage for 100 percent, under Medicare Part A or B, of the reasonable cost of
26.11 the first three pints of blood, or equivalent quantities of packed red blood cells, as defined
26.12 under federal regulations, unless replaced according to federal regulations;
26.13 (6) except for coverage provided in this clause, coverage for 100 percent of the cost
26.14 sharing otherwise applicable under Medicare Part B;
26.15 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
26.16 services and diagnostic procedures for cancer screening described in section 62A.30 after
26.17 the policyholder pays the Medicare Part B deductible;
26.18 (8) coverage of 100 percent of the hospital and medical expenses and supplies
26.19 incurred during travel outside of the United States as a result of a medical emergency;
26.20 (9) coverage for 100 percent of Medicare Part A and B home health care services
26.21 and medical supplies; and
26.22 (10) the basis for the deductible shall be $1,860 and shall be adjusted annually from
26.23 2010 by the secretary of the United States Department of Health and Human Services to
26.24 reflect the change in the Consumer Price Index for all urban consumers for the 12-month
26.25 period ending with August of the preceding year, and rounded to the nearest multiple of
26.26 $10.

26.27 Sec. 31. Minnesota Statutes 2008, section 62L.02, subdivision 26, is amended to read:
26.28 Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar
26.29 year and a plan year, a person, firm, corporation, partnership, association, or other entity
26.30 actively engaged in business in Minnesota, including a political subdivision of the state,
26.31 that employed an average of no fewer than two nor more than 50 current employees on
26.32 business days during the preceding calendar year and that employs at least two current
26.33 employees on the first day of the plan year. If an employer has only one eligible employee
26.34 who has not waived coverage, the sale of a health plan to or for that eligible employee
26.35 is not a sale to a small employer and is not subject to this chapter and may be treated as

27.1 the sale of an individual health plan. A small employer plan may be offered through a
27.2 domiciled association to self-employed individuals and small employers who are members
27.3 of the association, even if the self-employed individual or small employer has fewer than
27.4 two current employees. Entities that are treated as a single employer under subsection (b),
27.5 (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single
27.6 employer for purposes of determining the number of current employees. Small employer
27.7 status must be determined on an annual basis as of the renewal date of the health benefit
27.8 plan. The provisions of this chapter continue to apply to an employer who no longer meets
27.9 the requirements of this definition until the annual renewal date of the employer's health
27.10 benefit plan. If an employer was not in existence throughout the preceding calendar year,
27.11 the determination of whether the employer is a small employer is based upon the average
27.12 number of current employees that it is reasonably expected that the employer will employ
27.13 on business days in the current calendar year. For purposes of this definition, the term
27.14 employer includes any predecessor of the employer. An employer that has more than 50
27.15 current employees but has 50 or fewer employees, as "employee" is defined under United
27.16 States Code, title 29, section 1002(6), is a small employer under this subdivision.

27.17 (b) Where an association, as defined in section 62L.045, comprised of employers
27.18 contracts with a health carrier to provide coverage to its members who are small employers,
27.19 the association and health benefit plans it provides to small employers, are subject to
27.20 section 62L.045, with respect to small employers in the association, even though the
27.21 association also provides coverage to its members that do not qualify as small employers.

27.22 (c) If an employer has employees covered under a trust specified in a collective
27.23 bargaining agreement under the federal Labor-Management Relations Act of 1947,
27.24 United States Code, title 29, section 141, et seq., as amended, or employees whose health
27.25 coverage is determined by a collective bargaining agreement and, as a result of the
27.26 collective bargaining agreement, is purchased separately from the health plan provided
27.27 to other employees, those employees are excluded in determining whether the employer
27.28 qualifies as a small employer. Those employees are considered to be a separate small
27.29 employer if they constitute a group that would qualify as a small employer in the absence
27.30 of the employees who are not subject to the collective bargaining agreement.

27.31 Sec. 32. Minnesota Statutes 2008, section 62M.05, subdivision 3a, is amended to read:

27.32 Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an
27.33 initial determination on all requests for utilization review must be communicated to the
27.34 provider and enrollee in accordance with this subdivision within ten business days of the

28.1 request, provided that all information reasonably necessary to make a determination on the
28.2 request has been made available to the utilization review organization.
28.3 (b) When an initial determination is made to certify, notification must be provided
28.4 promptly by telephone to the provider. The utilization review organization shall send
28.5 written notification to the provider or shall maintain an audit trail of the determination
28.6 and telephone notification. For purposes of this subdivision, "audit trail" includes
28.7 documentation of the telephone notification, including the date; the name of the person
28.8 spoken to; the enrollee; the service, procedure, or admission certified; and the date of
28.9 the service, procedure, or admission. If the utilization review organization indicates
28.10 certification by use of a number, the number must be called the "certification number."
28.11 For purposes of this subdivision, notification may also be made by facsimile to a verified
28.12 number or by electronic mail to a secure electronic mailbox. These electronic forms of
28.13 notification satisfy the "audit trail" requirement of this paragraph.
28.14 (c) When an initial determination is made not to certify, notification must be
28.15 provided by telephone, by facsimile to a verified number, or by electronic mail to a
28.16 secure electronic mailbox within one working day after making the determination to
28.17 the attending health care professional and hospital ~~and a written~~ as applicable. Written
28.18 notification must also be sent to the hospital~~,~~ as applicable and attending health care
28.19 professional~~, and enrollee~~ if notification occurred by telephone. For purposes of this
28.20 subdivision, notification may be made by facsimile to a verified number or by electronic
28.21 mail to a secure electronic mailbox. Written notification must be sent to the enrollee and
28.22 may be sent by United States mail, facsimile to a verified number, or by electronic mail to
28.23 a secure mailbox. The written notification must include the principal reason or reasons
28.24 for the determination and the process for initiating an appeal of the determination. Upon
28.25 request, the utilization review organization shall provide the provider or enrollee with the
28.26 criteria used to determine the necessity, appropriateness, and efficacy of the health care
28.27 service and identify the database, professional treatment parameter, or other basis for the
28.28 criteria. Reasons for a determination not to certify may include, among other things,
28.29 the lack of adequate information to certify after a reasonable attempt has been made to
28.30 contact the provider or enrollee.
28.31 (d) When an initial determination is made not to certify, the written notification must
28.32 inform the enrollee and the attending health care professional of the right to submit an
28.33 appeal to the internal appeal process described in section 62M.06 and the procedure
28.34 for initiating the internal appeal.

28.35 Sec. 33. Minnesota Statutes 2008, section 65A.27, subdivision 1, is amended to read:

29.1 Subdivision 1. **Scope.** For purposes of sections 65A.27 to ~~65A.30~~ 65A.302, the
29.2 following terms have the meanings given.

29.3 Sec. 34. Minnesota Statutes 2008, section 65A.29, is amended by adding a subdivision
29.4 to read:

29.5 Subd. 13. **Notice of possible cancellation.** (a) A written notice must be
29.6 provided to all applicants for homeowners' insurance, at the time the application is
29.7 submitted, containing the following language in bold print: "THE INSURER MAY
29.8 ELECT TO CANCEL COVERAGE AT ANY TIME DURING THE FIRST 60 DAYS
29.9 FOLLOWING ISSUANCE OF THE COVERAGE FOR ANY REASON WHICH IS
29.10 NOT SPECIFICALLY PROHIBITED BY STATUTE."

29.11 (b) If the insurer provides the notice on the insurer's Web site, the insurer or agent
29.12 may advise the applicant orally or in writing of its availability for review on the insurer's
29.13 Web site in lieu of providing a written notice, if the insurer advises the applicant of the
29.14 availability of a written notice upon the applicant's request. The insurer shall provide the
29.15 notice in writing if requested by the applicant. An oral notice shall be presumed delivered
29.16 if the agent or insurer makes a contemporaneous notation in the applicant's record of
29.17 the notice having been delivered or if the insurer or agent retains an audio recording of
29.18 the notification provided to the applicant.

29.19 **EFFECTIVE DATE.** This section is effective January 1, 2010.

29.20 Sec. 35. Minnesota Statutes 2008, section 65B.133, subdivision 2, is amended to read:

29.21 Subd. 2. **Disclosure to applicants.** Before accepting the initial premium payment,
29.22 an insurer or its agent shall provide a surcharge disclosure statement to any person who
29.23 applies for a policy which is effective on or after January 1, 1983. If the insurer provides
29.24 the surcharge disclosure statement on the insurer's website, the insurer or agent may notify
29.25 the applicant orally or in writing of its availability for review on the insurer's website
29.26 prior to accepting the initial payment, in lieu of providing a disclosure statement to the
29.27 applicant in writing, if the insurer so notifies the applicant of the availability of a written
29.28 version of this statement upon the applicant's request. The insurer shall provide the
29.29 surcharge disclosure statement in writing if requested by the applicant. An oral notice
29.30 shall be presumed delivered if the agent or insurer makes a contemporaneous notation in
29.31 the applicant's record of the notice having been delivered or if the insurer or agent retains
29.32 an audio recording of the notification provided to the applicant.

29.33 Sec. 36. Minnesota Statutes 2008, section 65B.133, subdivision 3, is amended to read:

30.1 Subd. 3. **Disclosure to policyholders.** An insurer or its agent shall mail or deliver
30.2 a surcharge disclosure statement or written notice of the statement's availability on the
30.3 insurer's website to the named insured either before or with the first notice to renew a
30.4 policy on or after January 1, 1983. If a surcharge disclosure statement or written website
30.5 notice has been provided pursuant to subdivision 2, no surcharge disclosure statement is
30.6 required to be mailed or delivered to the same named insured pursuant to subdivision 3.

30.7 Sec. 37. Minnesota Statutes 2008, section 65B.133, subdivision 4, is amended to read:
30.8 Subd. 4. **Notification of change.** No insurer may change its surcharge plan unless
30.9 a surcharge disclosure statement or written website notice is mailed or delivered to the
30.10 named insured before the change is made. A surcharge disclosure statement disclosing a
30.11 change applicable on the renewal of a policy, may be mailed with an offer to renew the
30.12 policy. Surcharges cannot be applied to accidents or traffic violations that occurred prior
30.13 to a change in a surcharge plan except to the extent provided under the prior plan.

30.14 Sec. 38. Minnesota Statutes 2008, section 65B.54, subdivision 1, is amended to read:
30.15 Subdivision 1. **Payment of basic economic loss benefits.** Basic economic loss
30.16 benefits are payable monthly as loss accrues. Loss accrues not when injury occurs, but as
30.17 income loss, replacement services loss, survivor's economic loss, survivor's replacement
30.18 services loss, or medical or funeral expense is incurred. Benefits are overdue if not
30.19 paid within 30 days after the reparation obligor receives reasonable proof of the fact
30.20 and amount of loss realized, unless the reparation obligor elects to accumulate claims
30.21 for periods not exceeding 31 days and pays them within 15 days after the period of
30.22 accumulation. If reasonable proof is supplied as to only part of a claim, and the part
30.23 totals $100 or more, the part is overdue if not paid within the time provided by this
30.24 section. Medical or funeral expense benefits may be paid by the reparation obligor
30.25 directly to persons supplying products, services, or accommodations to the claimant.
30.26 Claims by a health provider defined in section 62J.03, subdivision 8, for medical expense
30.27 benefits covered by this chapter shall be submitted to the reparation obligor pursuant to
30.28 the uniform electronic transaction standards required by section 62J.536 and the rules
30.29 promulgated under that section. Payment of benefits for such claims for medical expense
30.30 benefits are not due if the claim is not received by the reparation obligor pursuant to
30.31 those electronic transaction standards and rules. Notwithstanding any such submission,
30.32 a reparation obligor may require additional reasonable proof regarding the fact and the
30.33 amount of loss realized regarding such a claim. A health care provider cannot directly
30.34 bill an insured for the amount of any such claim not remitted pursuant to the transaction

standards required by section 62J.536 if the reparation obligor is acting in compliance with these standards in receiving or paying such a claim.

Sec. 39. Minnesota Statutes 2008, section 67A.191, subdivision 2, is amended to read:

Subd. 2. **Homeowner's risks.** A township mutual fire insurance company may issue policies known as "homeowner's insurance" as defined in section 65A.27, subdivision 4, only in combination with a policy issued by an insurer authorized to sell property and casualty insurance in this state. All portions of the combination policy providing homeowner's insurance, including those issued by a township mutual insurance company, ~~shall be~~ are subject to the provisions of chapter 65A and sections 72A.20 and 72A.201.

Sec. 40. Minnesota Statutes 2008, section 72A.20, subdivision 15, is amended to read:

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.~~; and

~~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:~~

32.1 ~~(a) the name which the arrangement intends to use and its business address;~~
32.2 ~~(b) the name, address, and nature of any separate organization which administers the~~
32.3 ~~arrangement on the behalf of the insurers; and~~
32.4 ~~(c) the names and addresses of all providers designated by the insurer under this~~
32.5 ~~clause and the terms of the agreements with designated health care providers.~~
32.6 ~~The commissioner shall maintain a record of arrangements proposed under this~~
32.7 ~~clause, including a record of any complaints submitted relative to the arrangements.~~
32.8 (5) in the case of an individual or group health insurance policy, offering incentives
32.9 to individuals for taking part in preventive health care services, medical management
32.10 incentive programs, or activities designed to improve the health of the individual.
32.11 If the commissioner requests copies of contracts with a provider under ~~this~~ clause (4)
32.12 and the provider requests a determination, all information contained in the contracts that
32.13 the commissioner determines may place the provider or health care plan at a competitive
32.14 disadvantage is nonpublic data.

32.15 Sec. 41. Minnesota Statutes 2008, section 72A.20, subdivision 26, is amended to read:
32.16 Subd. 26. **Loss experience.** An insurer shall without cost to the insured provide an
32.17 insured with the loss or claims experience of that insured for the current policy period and
32.18 for the two policy periods preceding the current one for which the insurer has provided
32.19 coverage, within 30 days of a request for the information by the policyholder. Whenever
32.20 reporting loss experience data, actual claims paid on behalf of the insured must be reported
32.21 separately from claims incurred but not paid, pooling charges for catastrophic claim
32.22 protection, and any other administrative fees or charges that may be charged as an incurred
32.23 claim expense. Claims experience data must be provided to the insured in accordance with
32.24 state and federal requirements regarding the confidentiality of medical data. The insurer
32.25 shall not be responsible for providing information without cost more often than once in
32.26 a 12-month period. The insurer is not required to provide the information if the policy
32.27 covers the employee of more than one employer and the information is not maintained
32.28 separately for each employer and not all employers request the data.
32.29 An insurer, health maintenance organization, or a third-party administrator may not
32.30 request more than three years of loss or claims experience as a condition of submitting an
32.31 application or providing coverage.
32.32 This subdivision only applies to group life policies and group health policies.

32.33 **EFFECTIVE DATE.** This section is effective for policy renewal proposals
32.34 delivered on or after August 1, 2010.

33.1 Sec. 42. Minnesota Statutes 2008, section 72A.201, is amended by adding a
33.2 subdivision to read:

33.3 Subd. 14. **Uniform electronic transaction standards.** Claims for medical
33.4 expenses under a property and casualty insurance policy subject to the uniform electronic
33.5 transaction standards required by section 62J.536 shall be submitted to an insurer by a
33.6 health care provider subject to that section pursuant to the uniform electronic transaction
33.7 standards and rules promulgated under that section. The exchange of information related
33.8 to such claims pursuant to the electronic transaction standards by an insurer shall not be
33.9 the sole basis for a finding that the insurer is not in compliance with the requirements of
33.10 this section, section 72A.20, and any rules promulgated under these sections.

33.11 Sec. 43. **[72A.204] PROHIBITED USES OF SENIOR-SPECIFIC**
33.12 **CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS.**

33.13 Subdivision 1. **Purpose and scope.** The purpose of this section is to set forth
33.14 standards to protect consumers from misleading and fraudulent marketing practices with
33.15 respect to the use of senior-specific certifications and professional designations in:

33.16 (1) the solicitation, sale, or purchase of a life insurance or annuity product; or

33.17 (2) the provision of advice in connection with the solicitation, sale, or purchase of a
33.18 life insurance or annuity product.

33.19 Subd. 2. **Insurance producer.** For purposes of this section, "insurance producer"
33.20 means a person required to be licensed under the laws of this state to sell, solicit, or
33.21 negotiate insurance, including annuities.

33.22 Subd. 3. **Prohibited uses of senior-specific certifications and professional**
33.23 **designations.** (a) It is an unfair and deceptive act or practice in the business of insurance
33.24 for an insurance producer to use a senior-specific certification or professional designation
33.25 that indicates or implies in such a way as to mislead a client or prospective client that the
33.26 insurance producer has special certification or training in advising or servicing seniors in
33.27 connection with the solicitation, sale, or purchase of a life insurance or annuity product or
33.28 in the provision of advice as to the value of or the advisability of purchasing or selling a
33.29 life insurance or annuity product, either directly or indirectly, including the provision of
33.30 advice through publications or writings or by issuing or promulgating analyses or reports
33.31 related to a life insurance or annuity product.

33.32 (b) The prohibited use of senior-specific certifications or professional designations
33.33 includes, but is not limited to, the following:

33.34 (1) use of a certification or professional designation by an insurance producer who
33.35 has not actually earned or is otherwise ineligible to use such certification or designation;

34.1 (2) use of a nonexistent or self-conferred certification or professional designation;
34.2 (3) use of a certification or professional designation that indicates or implies a level
34.3 of occupational qualifications obtained through education, training, or experience that the
34.4 insurance producer using the certification or designation does not have; and
34.5 (4) use of a certification or professional designation that was obtained from a
34.6 certifying or designating organization that:
34.7 (i) is primarily engaged in the business of instruction in sales or marketing;
34.8 (ii) does not have reasonable standards or procedures for ensuring the competency of
34.9 its certificants or designees;
34.10 (iii) does not have reasonable standards or procedures for monitoring and
34.11 disciplining its certificants or designees for improper or unethical conduct; or
34.12 (iv) does not have reasonable continuing education requirements for its certificants
34.13 or designees in order to maintain the certificate or designation.
34.14 (c) There is a rebuttable presumption that a certifying or designating organization is
34.15 not disqualified solely for the purposes of paragraph (b), clause (4), when the certification
34.16 or designation issued from the organization does not primarily apply to sales or marketing
34.17 and when the organization or the certification or designation in question has been
34.18 accredited by:
34.19 (1) the American National Standards Institute (ANSI);
34.20 (2) the National Commission for Certifying Agencies; or
34.21 (3) any organization that is on the United States Department of Education list
34.22 entitled "Accrediting Agencies Recognized for Title IV Purposes."
34.23 (d) In determining whether a combination of words or an acronym standing for a
34.24 combination of words constitutes a certification or professional designation indicating or
34.25 implying that a person has special certification or training in advising or servicing seniors,
34.26 factors to be considered must include:
34.27 (1) use of one or more words such as "senior," "retirement," "elder," or like words
34.28 combined with one or more words such as "certified," "registered," "chartered," "adviser,"
34.29 "specialist," "consultant," "planner," or like words, in the name of the certification or
34.30 professional designation; and
34.31 (2) the manner in which those words are combined.
34.32 (e) For purposes of this section, a job title within an organization that is licensed or
34.33 registered by a state or federal financial services regulatory agency is not a certification or
34.34 professional designation, unless it is used in a manner that would confuse or mislead a
34.35 reasonable consumer, when the job title:
34.36 (1) indicates seniority or standing within the organization; or

35.1 (2) specifies an individual's area of specialization within the organization.

35.2 (f) For purposes of paragraph (e), "financial services regulatory agency" includes,
35.3 but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers,
35.4 investment advisers, or investment companies as defined under the Investment Company
35.5 Act of 1940.

35.6 Sec. 44. Minnesota Statutes 2008, section 79A.04, subdivision 1, is amended to read:

35.7 Subdivision 1. **Annual securing of liability.** Each year every private self-insuring
35.8 employer shall secure incurred liabilities for the payment of compensation and the
35.9 performance of its obligations and the obligations of all self-insuring employers imposed
35.10 under chapter 176 by renewing the prior year's security deposit or by making a new
35.11 deposit of security. If a new deposit is made, it must be posted ~~within 60 days of the filing~~
35.12 ~~of the self-insured employer's annual report with the commissioner, but in no event later~~
35.13 ~~than July 1~~ in the following manner: within 60 days of the filing of the annual report, the
35.14 security posting for all prior years plus one-third of the posting for the current year; by
35.15 July 31, one-third of the posting for the current year; by October 31, the final one-third of
35.16 the posting for the current year.

35.17 Sec. 45. Minnesota Statutes 2008, section 79A.04, is amended by adding a subdivision
35.18 to read:

35.19 Subd. 2a. **Exceptions.** Notwithstanding the requirements of subdivisions 1
35.20 and 2, the commissioner may, until the next annual securing of liability, adjust this
35.21 required security deposit for the portion attributable to the current year only, if, in the
35.22 commissioner's judgment, the self-insurer will be able to meet its obligations under this
35.23 chapter until the next annual securing of liability.

35.24 Sec. 46. Minnesota Statutes 2008, section 79A.06, is amended by adding a subdivision
35.25 to read:

35.26 Subd. 7. **Insolvency of a self-insurance group insurer.** In the event of the
35.27 insolvency of the insurer of a self-insurance group issued a policy under section 79A.06,
35.28 subdivision 5, including a policy covering only a portion of the period of self-insurance,
35.29 eligibility for chapter 60C coverage under the policy shall be determined by applying the
35.30 requirements of section 60C.09, subdivision 2, clause (3), to each self-insurance group
35.31 member, rather than to the net worth of the self-insurance group entity or the aggregate net
35.32 worth of all members of the self-insurance group entity.

Sec. 47. Minnesota Statutes 2008, section 79A.24, subdivision 1, is amended to read:

Subdivision 1. **Annual securing of liability.** Each year every commercial self-insurance group shall secure its estimated future liability for the payment of compensation and the performance of the obligations of its membership imposed under chapter 176. A new deposit must be posted ~~within 30 days of the filing of the commercial self-insurance group's annual actuarial report with the commissioner~~ in the following manner: within 30 days of the filing of the annual report, the security posting for all prior years plus one-third of the posting for the current year; by July 31, one-third of the posting for the current year; by October 31, the final one-third of the posting for the current year.

Sec. 48. Minnesota Statutes 2008, section 79A.24, is amended by adding a subdivision to read:

Subd. 2a. **Exceptions.** Notwithstanding the requirements of subdivisions 1 and 2, the commissioner may, until the next annual securing of liability, adjust this required security deposit for the portion attributable to the current year only, if, in the commissioner's judgment, the self-insurer will be able to meet its obligations under this chapter until the next annual securing of liability.

Sec. 49. **[80A.91] AGENT ERRORS AND OMISSIONS INSURANCE; CHOICE OF SOURCE.**

A broker-dealer shall not require an agent to maintain insurance coverage for the agent's errors and omissions from a specific insurance company. This section does not apply if the agent is an employee of that broker-dealer, or if the broker-dealer or affiliated insurance company contributes to the premiums for the errors and omissions coverage. Nothing in this section shall prohibit a broker-dealer from requiring an agent to maintain errors and omissions coverage or requiring that the errors and omissions coverage meet certain criteria.

Sec. 50. Minnesota Statutes 2008, section 82.31, subdivision 4, is amended to read:

Subd. 4. **Corporate and partnership licenses.** (a) A corporation applying for a license shall have at least one officer individually licensed to act as broker for the corporation. The corporation broker's license shall extend no authority to act as broker to any person other than the corporate entity. Each officer who intends to act as a broker shall obtain a license.

37.1 (b) A partnership applying for a license shall have at least one partner individually
37.2 licensed to act as broker for the partnership. Each partner who intends to act as a broker
37.3 shall obtain a license.

37.4 (c) Applications for a license made by a corporation shall be verified by the president
37.5 and one other officer. Applications made by a partnership shall be verified by at least
37.6 two partners.

37.7 (d) Any partner or officer who ceases to act as broker for a partnership or corporation
37.8 shall notify the commissioner upon said termination. The individual licenses of all
37.9 salespersons acting on behalf of a corporation or partnership, are automatically ineffective
37.10 upon the revocation or suspension of the license of the partnership or corporation.
37.11 The commissioner may suspend or revoke the license of an officer or partner without
37.12 suspending or revoking the license of the corporation or partnership.

37.13 (e) The application of all officers of a corporation or partners in a partnership who
37.14 intend to act as a broker on behalf of a corporation or partnership shall accompany the
37.15 initial license application of the corporation or partnership. Officers or partners intending
37.16 to act as brokers subsequent to the licensing of the corporation or partnership shall procure
37.17 an individual real estate broker's license prior to acting in the capacity of a broker. No
37.18 corporate officer, or partner, who maintains a salesperson's license may exercise any
37.19 authority over any trust account administered by the broker nor may they be vested with
37.20 any supervisory authority over the broker.

37.21 (f) The corporation or partnership applicant shall make available upon request, such
37.22 records and data required by the commissioner for enforcement of this chapter.

37.23 (g) The commissioner may require further information, as the commissioner deems
37.24 appropriate, to administer the provisions and further the purposes of this chapter.

37.25 Sec. 51. **[82B.071] RECORDS.**

37.26 Subdivision 1. **Examination of records.** The commissioner may make examinations
37.27 within or without this state of each real estate appraiser's records at such reasonable time
37.28 and in such scope as is necessary to enforce the provisions of this chapter.

37.29 Subd. 2. **Retention.** Licensees shall keep a separate work file for each appraisal
37.30 assignment, which is to include copies of all contracts engaging his or her services for
37.31 the real estate appraisal, appraisal reports, and all data, information, and documentation
37.32 assembled and formulated by the appraiser to support the appraiser's opinions and
37.33 conclusions and to show compliance with USPAP, for a period of five years after
37.34 preparation, or at least two years after final disposition of any judicial proceedings in
37.35 which the appraiser provided testimony or was the subject of litigation related to the

38.1 assignment, whichever period expires last. Appropriate work file access and retrieval
38.2 arrangements must be made between any trainee and supervising appraiser if only one
38.3 party maintains custody of the work file.

38.4 Sec. 52. Minnesota Statutes 2008, section 82B.08, is amended by adding a subdivision
38.5 to read:

38.6 Subd. 3a. **Initial application.** The initial application for licensing of a trainee
38.7 real property appraiser must identify the name and address of the supervisory appraiser
38.8 or appraisers. Trainee real property appraisers licensed prior to the effective date of this
38.9 provision must identify the name and address of their supervisory appraiser or appraisers
38.10 at the time of license renewal. A trainee must notify the commissioner in writing within
38.11 ten days of terminating or changing their relationship with any supervisory appraiser.

38.12 The initial application for licensing of a certified residential real property appraiser
38.13 and certified general real property appraiser who intends to act in the capacity of a
38.14 supervisory appraiser must identify the name and address of the trainee real property
38.15 appraiser or appraisers they intend to supervise. A certified residential real property
38.16 appraiser and certified general real property appraiser licensed and acting in the capacity
38.17 of a supervisory appraiser prior to the effective date of this provision must, at the time of
38.18 license renewal, identify the name and address of any trainee real property appraiser or
38.19 appraisers under their supervision.

38.20 Sec. 53. **[82B.093] TRAINEE REAL PROPERTY APPRAISER.**

38.21 (a) A trainee real property appraiser shall be subject to direct supervision by a
38.22 certified residential real property appraiser or certified general real property appraiser in
38.23 good standing.

38.24 (b) A trainee real property appraiser is permitted to have more than one supervising
38.25 appraiser.

38.26 (c) The scope of practice for the trainee real property appraiser classification is the
38.27 appraisal of those properties which the supervising appraiser is permitted by his or her
38.28 current credential and that the supervising appraiser is qualified and competent to appraise.

38.29 (d) A trainee real property appraiser must have a supervisor signature on each
38.30 appraisal that he or she signs, or must be named in the appraisal as providing significant
38.31 real property appraisal assistance to receive credit for experience hours on his or her
38.32 experience log.

39.1 (e) The trainee real property appraiser must maintain copies of appraisal reports he
39.2 or she signed or copies of appraisal reports where he or she was named as providing
39.3 significant real property appraisal assistance.
39.4 (f) The trainee real property appraiser must maintain copies of work files relating to
39.5 appraisal reports he or she signed.
39.6 (g) Separate appraisal logs must be maintained for each supervising appraiser.

39.7 Sec. 54. **[82B.094] SUPERVISION OF TRAINEE REAL PROPERTY**
39.8 **APPRAISERS.**
39.9 (a) A certified residential real property appraiser or a certified general real property
39.10 appraiser, in good standing, may engage a trainee real property appraiser to assist in the
39.11 performance of real estate appraisals, provided that the certified residential real property
39.12 appraiser or a certified general real property appraiser:
39.13 (1) has not been the subject of any license or certificate suspension or revocation or
39.14 has not been prohibited from supervising activities in this state or any other state within
39.15 the previous two years;
39.16 (2) has no more than three trainee real property appraisers working under supervision
39.17 at any one time;
39.18 (3) actively and personally supervises the trainee real property appraiser, which
39.19 includes ensuring that research of general and specific data has been adequately conducted
39.20 and properly reported, application of appraisal principles and methodologies has been
39.21 properly applied, that the analysis is sound and adequately reported, and that any analyses,
39.22 opinions, or conclusions are adequately developed and reported so that the appraisal
39.23 report is not misleading;
39.24 (4) discusses with the trainee real property appraiser any necessary and appropriate
39.25 changes that are made to a report, involving any trainee appraiser, before it is transmitted
39.26 to the client. Changes not discussed with the trainee real property appraiser that are made
39.27 by the supervising appraiser must be provided in writing to the trainee real property
39.28 appraiser upon completion of the appraisal report;
39.29 (5) accompanies the trainee real property appraiser on the inspections of the subject
39.30 properties and drive-by inspections of the comparable sales on all appraisal assignments
39.31 for which the trainee will perform work until the trainee appraiser is determined to be
39.32 competent, in accordance with the competency rule of USPAP for the property type;
39.33 (6) accepts full responsibility for the appraisal report by signing and certifying
39.34 that the report complies with USPAP; and

40.1 (7) reviews and signs the trainee real property appraiser's appraisal report or reports
40.2 or if the trainee appraiser is not signing the report, states in the appraisal the name of the
40.3 trainee and scope of the trainee's significant contribution to the report.
40.4 (b) The supervising appraiser must review and sign the applicable experience log
40.5 required to be kept by the trainee real property appraiser.
40.6 (c) The supervising appraiser must notify the commissioner within ten days when
40.7 the supervision of a trainee real property appraiser has terminated or when the trainee
40.8 appraiser is no longer under the supervision of the supervising appraiser.
40.9 (d) The supervising appraiser must maintain a separate work file for each appraisal
40.10 assignment.
40.11 (e) The supervising appraiser must verify that any trainee real property appraiser that
40.12 is subject to supervision is properly licensed and in good standing with the commissioner.

40.13 Sec. 55. Minnesota Statutes 2008, section 82B.20, subdivision 2, is amended to read:
40.14 Subd. 2. **Conduct prohibited.** No person may:
40.15 (1) obtain or try to obtain a license under this chapter by knowingly making a
40.16 false statement, submitting false information, refusing to provide complete information
40.17 in response to a question in an application for license, or through any form of fraud or
40.18 misrepresentation;
40.19 (2) fail to meet the minimum qualifications established by this chapter;
40.20 (3) be convicted, including a conviction based upon a plea of guilty or nolo
40.21 contendere, of a crime that is substantially related to the qualifications, functions, and
40.22 duties of a person developing real estate appraisals and communicating real estate
40.23 appraisals to others;
40.24 (4) engage in an act or omission involving dishonesty, fraud, or misrepresentation
40.25 with the intent to substantially benefit the license holder or another person or with the
40.26 intent to substantially injure another person;
40.27 (5) engage in a violation of any of the standards for the development or
40.28 communication of real estate appraisals as provided in this chapter;
40.29 (6) fail or refuse without good cause to exercise reasonable diligence in developing
40.30 an appraisal, preparing an appraisal report, or communicating an appraisal;
40.31 (7) engage in negligence or incompetence in developing an appraisal, in preparing
40.32 an appraisal report, or in communicating an appraisal;
40.33 (8) willfully disregard or violate any of the provisions of this chapter or the rules of
40.34 the commissioner for the administration and enforcement of the provisions of this chapter;

41.1 (9) accept an appraisal assignment when the employment itself is contingent upon
41.2 the appraiser reporting a predetermined estimate, analysis, or opinion, or where the fee
41.3 to be paid is contingent upon the opinion, conclusion, or valuation reached, or upon the
41.4 consequences resulting from the appraisal assignment;

41.5 (10) violate the confidential nature of governmental records to which the person
41.6 gained access through employment or engagement as an appraiser by a governmental
41.7 agency;

41.8 (11) offer, pay, or give, and no person shall accept, any compensation or other thing
41.9 of value from a real estate appraiser by way of commission-splitting, rebate, finder's fee,
41.10 or otherwise in connection with a real estate appraisal. This prohibition does not apply
41.11 to transactions among persons licensed under this chapter if the transactions involve
41.12 appraisals for which the license is required;

41.13 (12) engage or authorize a person, except a person licensed under this chapter, to act
41.14 as a real estate appraiser on the appraiser's behalf;

41.15 (13) violate standards of professional practice;

41.16 (14) make an oral appraisal report without also making a written report within a
41.17 reasonable time after the oral report is made;

41.18 (15) represent a market analysis to be an appraisal report;

41.19 (16) give an appraisal in any circumstances where the appraiser has a conflict of
41.20 interest, as determined under rules adopted by the commissioner; or

41.21 (17) engage in other acts the commissioner by rule prohibits.

41.22 No person, including a mortgage originator, appraisal management company, real
41.23 estate broker or salesperson, appraiser, or other licensee, registrant, or certificate holder
41.24 regulated by the commissioner may improperly influence or attempt to improperly
41.25 influence the development, reporting, result, or review of a real estate appraisal. Prohibited
41.26 acts include blacklisting, boycotting, intimidation, coercion, and any other means that
41.27 impairs or may impair the independent judgment of the appraiser, including but not
41.28 limited to the withholding or threatened withholding of payment for an appraisal fee, or
41.29 the conditioning of the payment of any appraisal fee upon the opinion, conclusion, or
41.30 valuation to be reached, or a request that the appraiser report a predetermined opinion,
41.31 conclusion, or valuation, or the desired valuation of any person, or withholding or
41.32 threatening to withhold future work in order to obtain a desired value on a current or
41.33 proposed appraisal assignment.

41.34 Sec. 56. Minnesota Statutes 2008, section 319B.02, is amended by adding a
41.35 subdivision to read:

42.1 Subd. 21a. **Surviving spouse.** "Surviving spouse" means a surviving spouse of a
42.2 deceased professional as an individual, as the personal representative of the estate of the
42.3 decedent, as the trustee of an inter vivos or testamentary trust created by the decedent, or
42.4 as the sole heir or beneficiary of an estate or trust of which the personal representative or
42.5 trustee is a bank or other institution that has trust powers.

42.6 **EFFECTIVE DATE.** This section is effective the day following final enactment
42.7 and applies to surviving spouses of professionals who die on or after that date.

42.8 Sec. 57. Minnesota Statutes 2008, section 319B.07, subdivision 1, is amended to read:
42.9 Subdivision 1. **Ownership of interests restricted.** Ownership interests in a
42.10 professional firm may not be owned or held, either directly or indirectly, except by any of
42.11 the following:
42.12 (1) professionals who, with respect to at least one category of the pertinent
42.13 professional services, are licensed and not disqualified;
42.14 (2) general partnerships, other than limited liability partnerships, authorized to
42.15 furnish at least one category of the professional firm's pertinent professional services;
42.16 (3) other professional firms authorized to furnish at least one category of the
42.17 professional firm's pertinent professional services;
42.18 (4) a voting trust established with respect to some or all of the ownership interests
42.19 in the professional firm, if (i) the professional firm's generally applicable governing law
42.20 permits the establishment of voting trusts, and (ii) all the voting trustees and all the holders
42.21 of beneficial interests in the trust are professionals licensed to furnish at least one category
42.22 of the pertinent professional services; ~~and~~
42.23 (5) an employee stock ownership plan as defined in section 4975(e)(7) of the
42.24 Internal Revenue Code of 1986, as amended, if (i) all the voting trustees of the plan are
42.25 professionals licensed to furnish at least one category of the pertinent professional services,
42.26 and (ii) the ownership interests are not directly issued to anyone other than professionals
42.27 licensed to furnish at least one category of the pertinent professional services; and
42.28 (6) sole ownership by a surviving spouse of a deceased professional who was the
42.29 sole owner of the professional firm at the time of the professional's death, but only during
42.30 the period of time ending one year after the death of the professional.

42.31 **EFFECTIVE DATE.** This section is effective the day following final enactment
42.32 and applies to surviving spouses of professionals who die on or after that date.

43.1 Sec. 58. Minnesota Statutes 2008, section 319B.08, is amended to read:

43.2 **319B.08 EFFECT OF DEATH OR DISQUALIFICATION OF OWNER.**

43.3 Subdivision 1. **Acquisition of interests or automatic loss of professional**
43.4 **firm status.** (a) If an owner dies or becomes disqualified to practice all the pertinent
43.5 professional services, then either:

43.6 (1) within 90 days after the death or the beginning of the disqualification, all of
43.7 that owner's ownership interest must be acquired by the professional firm, by persons
43.8 permitted by section 319B.07 to own the ownership interest, or by some combination; or

43.9 (2) at the end of the 90-day period, the firm's election under section 319B.03,
43.10 subdivision 2, or 319B.04, subdivision 2, is automatically rescinded, the firm loses
43.11 its status as a professional firm, and the authority created by that election and status
43.12 terminates.

43.13 An acquisition satisfies clause (1) if all right and title to the deceased or disqualified
43.14 owner's interest are acquired before the end of the 90-day period, even if some or all of
43.15 the consideration is paid after the end of the 90-day period. However, payment cannot be
43.16 secured in any way that violates sections 319B.01 to 319B.12.

43.17 (b) If automatic rescission does occur under paragraph (a), the firm must immediately
43.18 and accordingly update its organizational document, certificate of authority, or statement
43.19 of foreign qualification. Even without that updating, however, the rescission, loss of
43.20 status, and termination of authority provided by paragraph (a) occur automatically at the
43.21 end of the 90-day period.

43.22 Subd. 2. **Terms of acquisition.** (a) If:

43.23 (1) an owner dies or becomes disqualified to practice all the pertinent professional
43.24 services;

43.25 (2) the professional firm has in effect a mechanism, valid according to the
43.26 professional firm's generally applicable governing law, to effect a purchase of the deceased
43.27 or disqualified owner's ownership interest so as to satisfy subdivision 1, paragraph (a),
43.28 clause (1); and

43.29 (3) the professional firm does not agree with the disqualified owner or the
43.30 representative of the deceased owner to set aside the mechanism,

43.31 then that mechanism applies.

43.32 (b) If:

43.33 (1) an owner dies or becomes disqualified to practice all the pertinent professional
43.34 services;

43.35 (2) the professional firm has in effect no mechanism as described in paragraph (a), or
43.36 has agreed as mentioned in paragraph (a), clause (3), to set aside that mechanism; and

44.1 (3) consistent with its generally applicable governing law, the professional firm
44.2 agrees with the disqualified owner or the representative of the deceased owner, before
44.3 the end of the 90-day period, to an arrangement to effect a purchase of the deceased
44.4 or disqualified owner's ownership interest so as to satisfy subdivision 1, paragraph (a),
44.5 clause (1),

44.6 then that arrangement applies.

44.7 (c) If:

44.8 (1) an owner of a Minnesota professional firm dies or becomes disqualified to
44.9 practice all the pertinent professional services;

44.10 (2) the Minnesota professional firm does not have in effect a mechanism as described
44.11 in paragraph (a);

44.12 (3) the Minnesota professional firm does not make an arrangement as described in
44.13 paragraph (b); and

44.14 (4) no provision or tenet of the Minnesota professional firm's generally applicable
44.15 governing law and no provision of any document or agreement authorized by the
44.16 Minnesota professional firm's generally applicable governing law expressly precludes an
44.17 acquisition under this paragraph,

44.18 then the firm may acquire the deceased or disqualified owner's ownership interest as
44.19 stated in this paragraph. To act under this paragraph, the Minnesota professional firm
44.20 must within 90 days after the death or beginning of the disqualification tender to the
44.21 representative of the deceased owner's estate or to the disqualified owner the fair value
44.22 of the owner's ownership interest, as determined by the Minnesota professional firm's
44.23 governance authority. That price must be at least the book value, as determined in
44.24 accordance with the Minnesota professional firm's regular method of accounting, as of the
44.25 end of the month immediately preceding the death or loss of license. The tender must be
44.26 unconditional and may not attempt to have the recipient waive any rights provided in this
44.27 section. If the Minnesota professional firm tenders a price under this paragraph within
44.28 the 90-day period, the deceased or disqualified owner's ownership interest immediately
44.29 transfers to the Minnesota professional firm regardless of any dispute as to the fairness
44.30 of the price. A disqualified owner or representative of the deceased owner's estate who
44.31 disputes the fairness of the tendered price may take the tendered price and bring suit
44.32 in district court seeking additional payment. The suit must be commenced within one
44.33 year after the payment is tendered. A Minnesota professional firm may agree with a
44.34 disqualified owner or the representative of a deceased owner's estate to delay all or part
44.35 of the payment due under this paragraph, but all right and title to the owner's ownership

45.1 interests must be acquired before the end of the 90-day period and payment may not be
45.2 secured in any way that violates sections 319B.01 to 319B.12.

45.3 Subd. 3. **Expiration of firm-issued option on death or disqualification of holder.**
45.4 If the holder of an option issued under section 319B.07, subdivision 3, paragraph (a),
45.5 clause (1), dies or becomes disqualified, the option automatically expires.

45.6 Subd. 4. **One-year period for surviving spouse of sole owner.** For purposes
45.7 of this section, each mention of "90 days," "90-day period," or similar term shall be
45.8 interpreted as one year after the death of a professional who was the sole owner of the
45.9 professional firm if the surviving spouse of the deceased professional owns and controls
45.10 the firm after the death.

45.11 **EFFECTIVE DATE.** This section is effective the day following final enactment
45.12 and applies to surviving spouses of professionals who die on or after that date.

45.13 Sec. 59. Minnesota Statutes 2008, section 319B.09, subdivision 1, is amended to read:

45.14 Subdivision 1. **Governance authority.** (a) Except as stated in paragraph (b), a
45.15 professional firm's governance authority must rest with:

45.16 (1) one or more professionals, each of whom is licensed to furnish at least one
45.17 category of the pertinent professional services; or

45.18 (2) a surviving spouse of a deceased professional who was the sole owner of the
45.19 professional firm, while the surviving spouse owns and controls the firm, but only during
45.20 the period of time ending one year after the death of the professional.

45.21 (b) In a Minnesota professional firm organized under chapter 317A and in a foreign
45.22 professional firm organized under the nonprofit corporation statute of another state, at least
45.23 one individual possessing governance authority must be a professional licensed to furnish
45.24 at least one category of the pertinent professional services.

45.25 (c) Individuals who possess governance authority within a professional firm may
45.26 delegate administrative and operational matters to others. No decision entailing the
45.27 exercise of professional judgment may be delegated or assigned to anyone who is not a
45.28 professional licensed to practice the professional services involved in the decision.

45.29 (d) An individual whose license to practice any pertinent professional services is
45.30 revoked or suspended may not, during the time the revocation or suspension is in effect,
45.31 possess or exercise governance authority, hold a position with governance authority,
45.32 or take part in any decision or other action constituting an exercise of governance
45.33 authority. Nothing in this chapter prevents a board from further terminating, restricting,
45.34 limiting, qualifying, or imposing conditions on an individual's governance role as board
45.35 disciplinary action.

46.1 (e) A professional firm owned and controlled by a surviving spouse must comply
46.2 with all requirements of this chapter, except those clearly inapplicable to a firm owned
46.3 and governed by a surviving spouse who is not a professional of the same type as the
46.4 surviving spouse's decedent.

46.5 **EFFECTIVE DATE.** This section is effective the day following final enactment
46.6 and applies to surviving spouses of professionals who die on or after that date.

46.7 Sec. 60. Minnesota Statutes 2008, section 325E.27, is amended to read:

46.8 **325E.27 USE OF PRERECORDED OR SYNTHESIZED VOICE MESSAGES.**

46.9 A caller shall not use or connect to a telephone line an automatic dialing-announcing
46.10 device unless: (1) the subscriber has knowingly or voluntarily requested, consented
46.11 to, permitted, or authorized receipt of the message; or (2) the message is immediately
46.12 preceded by a live operator who obtains the subscriber's consent before the message is
46.13 delivered. This section and section 325E.30 do not apply to (1) messages from school
46.14 districts to students, parents, or employees, (2) messages to subscribers with whom the
46.15 caller has a current business or personal relationship, or (3) messages advising employees
46.16 of work schedules. This section does not apply to messages from a nonprofit tax-exempt
46.17 charitable organization sent solely for the purpose of soliciting voluntary donations of
46.18 clothing to benefit disabled United States military veterans and containing no request for
46.19 monetary donations or other solicitations of any kind.

46.20 Sec. 61. **[325E.3161] TELEPHONE SOLICITATIONS; EXPIRATION**
46.21 **PROVISION.**

46.22 Sections 325E.311 to 325E.316 expire December 31, 2012.

46.23 Sec. 62. Minnesota Statutes 2008, section 332A.02, subdivision 13, as amended by
46.24 Laws 2009, chapter 37, article 4, section 12, is amended to read:

46.25 Subd. 13. **Debt settlement services provider.** "Debt settlement services provider"
46.26 has the meaning given in section 332B.02, subdivision ~~11~~ 13.

46.27 Sec. 63. Minnesota Statutes 2008, section 332A.14, as amended by Laws 2009, chapter
46.28 37, article 4, section 17, is amended to read:

46.29 **332A.14 PROHIBITIONS.**

46.30 No debt management services provider shall:

46.31 (1) purchase from a creditor any obligation of a debtor;

47.1 (2) use, threaten to use, seek to have used, or seek to have threatened the use of any
47.2 legal process, including but not limited to garnishment and repossession of personal
47.3 property, against any debtor while the debt management services agreement between the
47.4 registrant and the debtor remains executory;

47.5 (3) advise, counsel, or encourage a debtor to stop paying a creditor, or imply, infer,
47.6 encourage, or in any other way indicate, that it is advisable to stop paying a creditor;

47.7 (4) sanction or condone the act by a debtor of ceasing payments to a creditor or
47.8 imply, infer, or in any manner indicate that the act of ceasing payments to a creditor is
47.9 advisable or beneficial to the debtor;

47.10 (5) require as a condition of performing debt management services the purchase of
47.11 any services, stock, insurance, commodity, or other property or any interest therein either
47.12 by the debtor or the registrant;

47.13 (6) compromise any debts unless the prior written or contractual approval of the
47.14 debtor has been obtained to such compromise and unless such compromise inures solely
47.15 to the benefit of the debtor;

47.16 (7) receive from any debtor as security or in payment of any fee a promissory note
47.17 or other promise to pay or any mortgage or other security, whether as to real or personal
47.18 property;

47.19 (8) lend money or provide credit to any debtor if any interest or fee is charged,
47.20 or directly or indirectly collect any fee for referring, advising, procuring, arranging, or
47.21 assisting a consumer in obtaining any extension of credit or other debtor service from a
47.22 lender or debt management services provider;

47.23 (9) structure a debt management services agreement that would result in negative
47.24 amortization of any debt in the plan;

47.25 (10) engage in any unfair, deceptive, or unconscionable act or practice in connection
47.26 with any service provided to any debtor;

47.27 (11) offer, pay, or give any material cash fee, gift, bonus, premium, reward, or other
47.28 compensation to any person for referring any prospective customer to the registrant or for
47.29 enrolling a debtor in a debt management services plan, or provide any other incentives
47.30 for employees or agents of the debt management services provider to induce debtors to
47.31 enter into a debt management services plan;

47.32 (12) receive any cash, fee, gift, bonus, premium, reward, or other compensation
47.33 from any person other than the debtor or a person on the debtor's behalf in connection
47.34 with activities as a registrant, provided that this paragraph does not apply to a registrant
47.35 which is a bona fide nonprofit corporation duly organized under chapter 317A or under
47.36 the similar laws of another state;

48.1 (13) enter into a contract with a debtor unless a thorough written budget analysis
48.2 indicates that the debtor can reasonably meet the requirements of the financial adjustment
48.3 plan and will be benefited by the plan;
48.4 (14) in any way charge or purport to charge or provide any debtor credit insurance in
48.5 conjunction with any contract or agreement involved in the debt management services
48.6 plan;
48.7 (15) operate or employ a person who is an employee or owner of a collection agency
48.8 or process-serving business; or
48.9 (16) solicit, demand, collect, require, or attempt to require payment of a sum that
48.10 the registrant states, discloses, or advertises to be a voluntary contribution to a debt
48.11 management services provider or designee from the debtor.

48.12 Sec. 64. Minnesota Statutes 2008, section 332B.02, subdivision 13, as added by Laws
48.13 2009, chapter 37, article 4, section 19, is amended to read:
48.14 Subd. 13. **Debt settlement services provider.** "Debt settlement services provider"
48.15 means any person offering or providing debt settlement services to a debtor domiciled
48.16 in this state, regardless of whether or not a fee is charged for the services and regardless
48.17 of whether the person maintains a physical presence in the state. The term includes any
48.18 person to whom debt settlement ~~duties~~ services are delegated. The term shall not include
48.19 persons listed in section 332A.02, subdivision 8, clauses (1) to (10), or a debt management
48.20 services provider.

48.21 Sec. 65. Minnesota Statutes 2008, section 332B.03, as added by Laws 2009, chapter
48.22 37, article 4, section 20, is amended to read:

48.23 **332B.03 REQUIREMENT OF REGISTRATION.**

48.24 On or after August 1, 2009, it is unlawful for any person, whether or not located
48.25 in this state, to operate as a debt settlement services provider or provide debt settlement
48.26 services including, but not limited to, offering, advertising, or executing or causing to be
48.27 executed any debt settlement services or debt settlement services agreement, except as
48.28 authorized by law, without first becoming registered as provided in this chapter. Debt
48.29 settlement services providers may continue to provide debt settlement services without
48.30 complying with this chapter to those debtors who entered into a contract to participate
48.31 in a debt settlement services plan prior to August 1, 2009, but may not enter into a debt
48.32 settlement services agreement with a ~~debt~~ debtor on or after August 1, 2009, without
48.33 complying with this chapter.

Sec. 66. Minnesota Statutes 2008, section 332B.06, as added by Laws 2009, chapter 37, article 4, section 23, is amended to read:

332B.06 WRITTEN DEBT SETTLEMENT SERVICES AGREEMENT; DISCLOSURES; TRUST ACCOUNT.

Subdivision 1. **Written agreement required.** (a) A debt settlement services provider may not perform, or impose any charges or receive any payment for, any debt settlement services until the provider and the debtor have executed a debt settlement services agreement that contains all terms of the agreement between the debt settlement services provider and the debtor, and the provider complies with all the applicable requirements of this chapter.

(b) A debt settlement services agreement must:

(1) be in writing, dated, and signed by the debt settlement services provider and the debtor;

(2) conspicuously indicate whether or not the debt settlement services provider is registered with the Minnesota Department of Commerce and include any registration number; and

(3) be written in the debtor's primary language if the debt settlement services provider advertises in that language.

(c) The registrant must furnish the debtor with a copy of the signed contract upon execution.

Subd. 2. **Actions prior to executing a written agreement.** No person may provide debt settlement services for a debtor or execute a debt settlement services agreement unless the person first has:

(1) informed the debtor, in writing, that debt settlement is not appropriate for all debtors and that there are other ways to deal with debt, including using credit counseling or debt management services, or filing bankruptcy;

(2) prepared in writing and provided to the debtor, in a form the debtor may keep, an individualized financial analysis of the debtor's financial circumstances, including income and liabilities, and made a determination supported by the individualized financial analysis that:

(i) the debt settlement plan proposed for addressing the debt is suitable for the individual debtor;

(ii) the debtor can reasonably meet the requirements of the proposed debt settlement services plan; and

(iii) based on the totality of the circumstances, there is a net tangible benefit to the debtor of entering into the proposed debt settlement services plan; and

50.1 (3) provided, on a document separate from any other document, the total amount and
50.2 an itemization of fees, including any origination fees, monthly fees, and settlement fees
50.3 reasonably anticipated to be paid by the debtor over the term of the agreement.

50.4 Subd. 3. **Determination concerning creditor participation.** (a) Before executing a
50.5 debt settlement services agreement or providing any services, a debt settlement services
50.6 provider must make a determination, supported by sufficient bases, which creditors listed
50.7 by the debtor are reasonably likely, and which are not reasonably likely, to participate in
50.8 the debt settlement services plan set forth in the debt settlement services agreement.

50.9 (b) A debt settlement services provider has a defense against a claim that no
50.10 sufficient basis existed to make a determination that a creditor was likely to participate if
50.11 the debt settlement services provider can produce:

50.12 (1) written confirmation from the creditor that, at the time the determination was
50.13 made, the creditor and the debt settlement services provider were engaged in negotiations
50.14 to settle a debt for another debtor; or

50.15 (2) evidence that the provider and the creditor had entered into a settlement of a debt
50.16 for another debtor within the six months prior to the date of the determination.

50.17 (c) The debt settlement services provider must notify the debtor as soon as
50.18 practicable after the provider has made a determination of the likelihood of participation
50.19 or nonparticipation of all the creditors listed for inclusion in the debt settlement services
50.20 agreement or debt settlement services plan. If not all creditors listed in the debt settlement
50.21 services agreement are reasonably likely to participate in the debt settlement services plan,
50.22 the debt settlement services provider must obtain the written authorization from the debtor
50.23 to proceed with the debt settlement services agreement without the likely participation of
50.24 all listed creditors.

50.25 Subd. 4. **Disclosures.** (a) A person offering to provide or providing debt settlement
50.26 services must disclose both orally and in writing whether or not the person is registered
50.27 with the Minnesota Department of Commerce and any registration number.

50.28 (b) No person may provide debt settlement services unless the person first has
50.29 provided, both orally and in writing, on a single sheet of paper, separate from any other
50.30 document or writing, the following verbatim notice:

50.31 **CAUTION**

50.32 We CANNOT GUARANTEE that you will successfully reduce or eliminate your
50.33 debt.

50.34 If you stop paying your creditors, there is a strong likelihood some or all of the
50.35 following may happen:

50.36 • YOUR WAGES OR BANK ACCOUNT MAY STILL BE GARNISHED.

51.1 • YOU MAY STILL BE CONTACTED BY CREDITORS.
51.2 • YOU MAY STILL BE SUED BY CREDITORS for the money you owe.
51.3 • FEES, INTEREST, AND OTHER CHARGES WILL CONTINUE TO MOUNT
51.4 UP DURING THE (INSERT NUMBER) MONTHS THIS PLAN IS IN EFFECT.
51.5 Even if we do settle your debt, YOU MAY STILL HAVE TO PAY TAXES on
51.6 the amount forgiven.
51.7 Your credit rating may be adversely affected.
51.8 (c) The heading, "CAUTION," must be in bold, underlined, 28-point type, and the
51.9 remaining text must be in 14-point type, with a double space between each statement.
51.10 (d) The disclosures and notices required under this subdivision must be provided
51.11 in the debtor's primary language if the debt settlement services provider advertises in
51.12 that language.
51.13 Subd. 5. **Required terms.** (a) Each debt settlement services agreement must contain
51.14 on the front page of the agreement, segregated by bold lines from all other information
51.15 on the page and disclosed prominently and clearly in bold print, the total amount and an
51.16 itemization of fees, including any origination fees, monthly fees, and settlement fees
51.17 reasonably anticipated to be paid by the debtor over the term of the agreement.
51.18 (b) Each debt settlement services agreement must also contain the following:
51.19 (1) a prominent statement describing the terms upon which the debtor may cancel
51.20 the contract as set forth in section 332B.07;
51.21 (2) a detailed description of all services to be performed by the debt settlement
51.22 services provider for the debtor;
51.23 (3) the debt settlement services provider's refund policy;
51.24 (4) the debt settlement services provider's principal business address, which must
51.25 not be a post office box, and the name and address of its agent in this state authorized to
51.26 receive service of process; and
51.27 (5) the name of each creditor the debtor has listed and the aggregate debt owed to
51.28 each creditor that will be the subject of settlement.
51.29 Subd. 6. **Prohibited terms.** A debt settlement services agreement may not contain
51.30 any of the terms prohibited under section 332A.10, subdivision 4.
51.31 Subd. 7. **New debt settlement services agreements; modifications of existing**
51.32 **agreements.** (a) Separate and additional debt settlement services agreements that comply
51.33 with this chapter may be entered into by the debt settlement services provider and the
51.34 debtor, provided that no additional origination fee may be charged by the debt settlement
51.35 services provider.

52.1 (b) Any modification of an existing debt settlement services agreement, including
52.2 any increase in the number or amount of debts included in the debt settlement services
52.3 agreement, must be in writing and signed by both parties. No fee may be charged to
52.4 modify an existing agreement.

52.5 Subd. 8. **Funds held in trust.** Debtor funds may be held in trust for the purpose
52.6 of writing exchange checks for no longer than 42 days. If the registrant holds debtor
52.7 funds, the registrant must maintain a separate trust account, except that the registrant may
52.8 commingle debtor funds with the registrant's own funds, in the form of an imprest fund,
52.9 to the extent necessary to ensure maintenance of a minimum balance, if the financial
52.10 institution at which the trust account is held requires a minimum balance to avoid the
52.11 assessment of fees or penalties for failure to maintain a minimum balance.

52.12 Sec. 67. Minnesota Statutes 2008, section 332B.09, as added by Laws 2009, chapter
52.13 37, article 4, section 26, is amended to read:

52.14 **332B.09 FEES; WITHDRAWAL OF CREDITORS; NOTIFICATION TO**
52.15 **DEBTOR OF SETTLEMENT OFFER.**

52.16 Subdivision 1. **Choice of fee structure.** A debt settlement services provider may
52.17 calculate fees on a percentage of debt basis or on a percentage of savings basis. The fee
52.18 structure shall be clearly disclosed and explained in the debt settlement services agreement.

52.19 Subd. 2. **Fees as a percentage of debt.** (a) The total amount of the fees claimed,
52.20 demanded, charged, collected, or received under this subdivision shall be calculated as
52.21 15 percent of the aggregate debt. A debt settlement services provider that calculates
52.22 fees as a percentage of debt may:

52.23 (1) charge an origination fee, which may be designated by the debt settlement
52.24 services provider as nonrefundable, of:

52.25 (i) $200 on aggregate debt of less than $20,000; or

52.26 (ii) $400 on aggregate debt of $20,000 or more;

52.27 (2) charge a monthly fee of:

52.28 (i) no greater than $50 per month on aggregate debt of less than $40,000; and

52.29 (ii) no greater than $60 per month on aggregate debt of $40,000 or more; and

52.30 (3) charge a settlement fee for the remainder of the allowable fees, which may be
52.31 demanded and collected no earlier than upon delivery to the debt settlement services
52.32 provider by a creditor of a bona fide written settlement offer consistent with the terms of
52.33 the debt settlement services agreement. A settlement fee may be assessed for each debt
52.34 settled, but the sum total of the origination fee, the monthly fee, and the settlement fee
52.35 may not exceed 15 percent of the aggregate debt.

(b) ~~When a settlement offer is obtained by a debt settlement services provider from a creditor, the collection of any monthly fees shall cease beginning the month following the month in which the settlement offer was obtained by the debt settlement services provider~~ <u>The collection of monthly fees shall cease under this subdivision when the total monthly fees and the origination fee equals 40 percent of the total fees allowable under this subdivision</u>.

(c) In no event may more than 40 percent of the total amount of fees allowable be claimed, demanded, charged, collected, or received by a debt settlement services provider any earlier than upon delivery to the debt settlement services provider by a creditor of a bona fide written settlement offer consistent with the terms of the debt settlement services agreement.

Subd. 3. **Fees as a percentage of savings.** (a) The total amount of the fees claimed, demanded, charged, collected, or received under this subdivision shall be calculated as 30 percent of the savings actually negotiated by the debt settlement services provider. The savings shall be calculated as the difference between the aggregate debt that is stated in the debt settlement services agreement at the time of its execution and total amount that the debtor actually pays to settle all the debts stated in the debt settlement services agreement, provided that only savings resulting from concessions actually negotiated by the debt settlement services provider may be counted. A debt settlement services provider that calculates fees as a percentage of debt may:

(1) charge an origination fee, which may be designated by the debt settlement services provider as nonrefundable, of:

(i) $300 on aggregate debt of less than $20,000; or

(ii) $500 on aggregate debt of $20,000 or more;

(2) charge a monthly fee of:

(i) no greater than $65 on aggregate debt of less than $40,000; and

(ii) no greater than $75 on aggregate debt of $40,000 or more; and

(3) charge a settlement fee for the remainder of the allowable fees, which may be demanded and collected no earlier than upon delivery to the debt settlement services provider by a creditor of a bona fide, final written settlement offer consistent with the terms of the debt settlement services agreement. A settlement fee may be assessed for each debt settled, but the sum total of the origination fee, the monthly fee, and the settlement fee may not exceed 30 percent of the savings, as calculated under paragraph (a).

(b) The collection of monthly fees shall cease under this subdivision when the total of monthly fees and the origination fee equals 50 percent of the total fees allowable

under this subdivision. For the purposes of this subdivision, 50 percent of the total fees allowable shall assume a settlement of 50 cents on the dollar.

(c) In no event may more than 50 percent of the total amount of fees allowable be claimed, demanded, charged, collected, or received by a debt settlement services provider any earlier than upon delivery to the debt settlement services provider by a creditor of a bona fide, final written settlement offer consistent with the terms of the debt settlement services agreement.

Subd. 4. **Fees exclusive.** No fees, charges, assessments, or any other compensation may be claimed, demanded, charged, collected, or received other than the fees allowed under this section. Any fees collected in excess of those allowed under this section must be immediately returned to the debtor.

Subd. 5. **Withdrawal of creditor.** Whenever a creditor withdraws from a debt settlement services plan, the debt settlement services provider must promptly notify the debtor of the withdrawal, identify the creditor, and inform the debtor of the right to modify the debt settlement services agreement, unless at least 50 percent of the listed creditors withdraw, in which case the debt settlement services provider must notify the debtor of the debtor's right to cancel. In no case may this notice be provided more than 15 days after the debt settlement services provider learns of the creditor's decision to withdraw from a plan.

Subd. 6. **Timely notification of settlement offer.** A debt settlement services provider must make all reasonable efforts to notify the debtor within 24 hours of a settlement offer made by a creditor.

Sec. 68. Laws 2008, chapter 315, section 19, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, ~~2009~~ 2010.

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 69. **REPEALER.**

Minnesota Statutes 2008, sections 60A.201, subdivision 4; 70A.07; and 79.56, subdivision 4, are repealed.

Sec. 70. **EFFECTIVE DATE.**

(a) Section 25 is effective for all policies with policy years beginning on or after May 21, 2009.

(b) Sections 26 to 30 apply to plans and certificates with an effective date for coverage on or after June 1, 2010.

55.1 (c) Sections 44 to 48 are effective the day following final enactment.

55.2 ARTICLE 2

55.3 DATA PRACTICES PROVISIONS RELATING TO COMMERCE

55.4 Section 1. Minnesota Statutes 2008, section 13.3215, is amended to read:

55.5 **13.3215 UNIVERSITY OF MINNESOTA DATA.**

55.6 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms in this
55.7 subdivision have the meanings given them.

55.8 (b) "Business data" is data described in section 13.591, subdivision 1, and includes
55.9 the funded amount of the University of Minnesota's commitment to the investment to
55.10 date, if any; the market value of the investment by the University of Minnesota; and the
55.11 age of the investment in years.

55.12 (c) "Financial, business, or proprietary data" means data, as determined by the
55.13 responsible authority for the University of Minnesota, that is of a financial, business, or
55.14 proprietary nature, the release of which could cause competitive harm to the University
55.15 of Minnesota, the legal entity in which the University of Minnesota has invested or has
55.16 considered an investment, the managing entity of an investment, or a portfolio company in
55.17 which the legal entity holds an interest.

55.18 (d) "Investment" means the investments by the University of Minnesota in the
55.19 following private capital:

55.20 (1) venture capital and other private equity investment businesses through
55.21 participation in limited partnerships, trusts, limited liability corporations, limited liability
55.22 companies, limited liability partnerships, and corporations;

55.23 (2) real estate ownership interests or loans secured by mortgages or deeds of trust or
55.24 shares of real estate investment trusts through investment in limited partnerships; and

55.25 (3) natural resource investments through limited partnerships, trusts, limited liability
55.26 corporations, limited liability companies, limited liability partnerships, and corporations.

55.27 Subd. 2. **Claims experience data.** Claims experience and all related information
55.28 received from carriers and claims administrators participating in a University of Minnesota
55.29 group health, dental, life, or disability insurance plan or the University of Minnesota
55.30 workers' compensation program, and survey information collected from employees or
55.31 students participating in these plans and programs, except when the university determines
55.32 that release of the data will not be detrimental to the plan or program, are classified as
55.33 nonpublic data ~~not on individuals pursuant to~~ under section 13.02, subdivision 9.

56.1 Subd. 3. **Private equity investment data.** (a) Financial, business, or proprietary
56.2 data collected, created, received, or maintained by the University of Minnesota in
56.3 connection with investments are nonpublic data.
56.4 (b) The following data shall be public:
56.5 (1) the name of the general partners and the legal entity in which the University of
56.6 Minnesota has invested;
56.7 (2) the amount of the University's initial commitment, and any subsequent
56.8 commitments;
56.9 (3) quarterly reports which outline the aggregate investment performance achieved
56.10 and the market value, and the fees and expenses paid in aggregate to general partner
56.11 investment managers in each of the following specific asset classes: venture capital,
56.12 private equity, distressed debt, private real estate, and natural resources;
56.13 (4) a description of all of the types of industry sectors the University of Minnesota is
56.14 or has invested in, in each specific private equity asset class;
56.15 (5) the portfolio performance of University of Minnesota investments overall,
56.16 including the number of investments, the total amount of the University of Minnesota
56.17 commitments, the total current market value, and the return on the total investment
56.18 portfolio; and
56.19 (6) the University's percentage ownership interest in a fund or investment entity in
56.20 which the University is invested.

56.21 **EFFECTIVE DATE.** This section is effective the day following final enactment.

56.22 Sec. 2. Minnesota Statutes 2008, section 13.716, is amended by adding a subdivision
56.23 to read:
56.24 Subd. 8. **Insurance filings data.** Insurance filings data received by the
56.25 commissioner of commerce are classified under section 60A.08, subdivision 15.

APPENDIX
Article locations in H1853-3

ARTICLE 1 REGULATION OF COMMERCE .... Page.Ln 2.1
ARTICLE 2 DATA PRACTICES PROVISIONS RELATING TO COMMERCE ... Page.Ln 55.2

60A.201 PLACEMENT OF INSURANCE BY LICENSEE.

Subd. 4. **Lists of unavailable lines of insurance; maintenance.** The commissioner shall maintain on a current basis a list of those lines of insurance for which coverages are believed by the commissioner to be generally unavailable from licensed insurers. The commissioner shall republish a list and make it available to all licensees at least annually. Any person may request in writing that the commissioner add or remove coverage from the current list at the next publication of the list. The commissioner's determinations of coverages to be added to or removed from the list shall not be subject to the Administrative Procedure Act but prior to making determinations the commissioner shall provide opportunity for comment from interested parties.

70A.07 RATES AND FORMS OPEN TO INSPECTION.

All rates, supplementary rate information, and forms furnished to the commissioner under this chapter shall, within ten days after their effective date, be open to public inspection at any reasonable time.

79.56 FILING RATES AND RATING INFORMATION.

Subd. 4. **Public inspection.** All filings shall be open to public inspection during normal business hours at the offices of the Department of Commerce.