CHAPTER 62I

JOINT UNDERWRITING ASSOCIATION

62I.01 CITATION.

Sections 62I.01 to 62I.22 may be cited as the Minnesota joint underwriting association act.

History: *1986 c 455 s 20*

62I.02 MINNESOTA JOINT UNDERWRITING ASSOCIATION.

Subdivision 1. **Creation.** The Minnesota joint underwriting association is created to provide insurance coverage to any person or entity unable to obtain insurance through ordinary methods if the insurance is required by statute, ordinance, or otherwise required by law, or is necessary to earn a livelihood or conduct a business and serves a public purpose. Prudent business practice or mere desire to have insurance coverage is not a sufficient standard for the association to offer insurance coverage to a person or entity. For purposes of this subdivision, directors' and officers' liability insurance is considered to be a business necessity and not merely a prudent business practice. The association shall be specifically authorized to provide insurance coverage to day care providers, foster parents, foster homes, developmental achievement centers, group homes, and rehabilitation facilities for mentally, emotionally, or physically handicapped persons, and citizen participation groups established pursuant to the housing and community redevelopment act of 1974, Public Law Number 93-383. Because the activities of certain persons or entities present a risk that is so great, the association shall not offer insurance coverage to any person or entity the board of directors of the association determines is outside the intended scope and purpose of the association because of the gravity of the risk of offering insurance coverage. The association shall not offer environmental impairment liability or product liability insurance. The association shall not offer coverage for activities that are conducted substantially outside the state of Minnesota unless the insurance is required by statute, ordinance, or otherwise required by law. Every insurer authorized to write property and casualty insurance in this state shall be a member of the association as a condition to obtaining and retaining a license to write insurance in this state.

Subd. 2. **Director.** The association shall have a board of directors composed of 11 persons chosen as follows: five persons elected by members of the association at a meeting called by the commissioner; three public members, as defined in section 214.02, appointed by the commissioner; and three members, appointed by the commissioner representing groups to whom coverage has been extended by the association. The terms of the members shall be four years. Terms may be staggered so that no more than six members are appointed or elected every two years. Members may serve until their successors are appointed or elected. If at any time no coverage is currently extended by the association, then either additional public members may be appointed to fill these three positions or, at the option of the commissioner, representatives from groups who had previously been covered by the association may serve as directors.

Subd. 3. **Reauthorization.** The authorization to issue insurance to day care providers, foster parents, foster homes, developmental activity centers, group homes, and rehabilitation facilities for mentally, emotionally, or physically handicapped persons, and citizen participation groups established pursuant to the housing and community redevelopment act of 1974, Public Law Number 93-383, is valid for a period of two years from the date it was made. The commissioner may reauthorize the issuance of insurance for these groups and other classes of business for additional two-year periods pursuant to sections 62I.21 and 62I.22. This subdivision is not a limitation on the number of times the commissioner may reauthorize the issuance of insurance.

History: *1986 c 455 s 21; 1Sp1986 c 3 art 2 s 43; 1987 c 337 s 77,78; 1988 c 689 art 2 s 268; 1989 c 260 s 7*

62I.03 DEFINITION.

Subdivision 1. **Scope.** As used in sections 62I.01 to 62I.22 the following terms have the meanings given them in this section.

Subd. 2. **Association.** "Association" means the Minnesota joint underwriting association.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 4. **Direct written premiums.** "Direct written premiums" means that amount at column (2), lines 5, 8, 9, 17, 21.2, 22, 23, 24, 25, 26, and 27, page 14, of the annual statement filed annually with the department of commerce pursuant to section 60A.13.

Subd. 5. **Deficit.** "Deficit" means, for a particular policy year, that amount by which total paid and outstanding losses and loss adjustment expenses exceed premium revenue, including retrospective premium revenue.

History: *1986 c 455 s 22; 1987 c 337 s 79*

62I.04 POLICY ISSUANCE.

Any person or entity that is a resident of the state of Minnesota who has a current notice of refusal to insure from an insurer licensed to offer insurance in the state of Minnesota may make written application to the association for coverage. The applicable premium or required portion of it must be paid prior to coverage by the association.

The application shall be filed simultaneously with the association and the market assistance plan for the association.

The association is authorized to (1) issue or cause to be issued insurance policies to applicants subject to limits specified in the plan of operation; (2) underwrite the insurance and adjust and pay losses with respect to it, or appoint service companies to perform those functions; (3) assume reinsurance from its members; and (4) cede reinsurance.

History: *1986 c 455 s 23; 1987 c 337 s 80*

62I.05 PLAN OF OPERATION.

Within 45 days after the appointment of the directors of the association, the directors shall submit to the commissioner for review, a proposed plan of operation, consistent with the provisions of this chapter.

The plan of operation shall provide economic, fair, and nondiscriminatory administration and for the prompt, efficient provision of insurance coverage of the types provided by section 62I.01. It shall provide for an expedited review and determination by the board of any application for a type of coverage that has not been previously excluded or authorized. The action of the board on the application shall be an amendment to the plan of operation and the type of coverage shall thereafter be specified in the plan as either excluded or authorized. It may contain other provisions necessary for the operation of the association, including but not limited to preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to

defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cessation of reinsurance, appointment of servicing carriers or other servicing arrangements and procedures for determining amounts of insurance to be provided by the association.

The plan of operation is subject to approval by the commissioner. If the commissioner disapproves all or any part of the proposed plan of operation, the directors shall within 15 days submit for review an appropriate revised plan of operation. If a revised plan is not submitted within 15 days the commissioner shall promulgate a plan of operation. The plan of operation approved or promulgated by the commissioner is effective and operational upon the order of the commissioner.

Amendments to the plan of operation may be made by the directors of the association subject to approval by the commissioner.

History: *1986 c 455 s 24*

62I.06 POLICY FORMS; PREMIUM RATE.

Subdivision 1. **Requirement.** The policies and contracts of coverage issued pursuant to this chapter shall contain the usual and customary provisions of similar insurance policies issued by private insurance companies. If a standard form is used in the private marketplace for any type of coverage that is to be extended by the association, then the association shall use that form. If there are varying types of forms used in the marketplace the association may choose to use a standard policy form issued by a service organization or other entity who commonly prepares standardized types of forms. If the board determines that neither of these alternatives is appropriate, then it shall adopt a policy form based upon the terms and conditions of the policies used for this type of coverage that are the most commonly used in the private market. As far as practical the board shall attempt to adopt forms that are consistent with the practice in the private market. No policy forms shall be used by the association unless it has been filed with the commissioner, and the commissioner may disapprove the form within 30 days if the commissioner determines that it is misleading, it violates public policy, or for any reason that the commissioner would be empowered to reject a similar form filed by a private company.

Subd. 2. **Cancellation.** If the insured fails to pay a stabilization reserve fund charge the association may cancel the policy by mailing or delivering to the insured at the insured's address shown on the policy at least ten days written notice stating the date that the cancellation is effective.

Subd. 3. **Rates.** The rates, rating plan, rating rules, rating classification and territories applicable to insurance written by the association and related statistics are subject to chapter 70A. Rates shall be on an actuarially sound basis, giving consideration to the group retrospective rating plan. The commissioner shall take all appropriate steps to make available, upon request of the association, loss and expense experience of insurers previously writing or currently writing insurance of any type the association offers or intends to offer.

Subd. 4. **Approval.** All policies issued by the association are subject to the group retrospective rating plan approved by the commissioner under which the final premium for the insureds of the association, as a group, will be equal to the administrative expenses, loss and loss adjustment expenses and taxes, plus a reasonable allowance for contingency and servicing. If the board of directors feels it is appropriate and in the interest of fairness and equity, the insureds of the association may be broken down into more than one group. The rating plan may provide for varying rates within the rating plan for such groups as their relative burden to the group as a whole would merit. Policyholders shall be given full credit for all investment income, net of expenses and reasonable management fee on policyholder supplied funds. The standard premium, before retrospective adjustment, for each policy issued by the association shall be established for portions of the policy period coinciding with the association's fiscal year on the basis of the association rates, rating plans, rating rules, rating classifications and territories then in effect. The maximum premium for all policyholders of the association as a group shall be limited as provided in sections 62I.01 to 62I.22.

Subd. 5. **Examinations.** The commissioner shall examine the business of the association as often as is appropriate to insure that the group retrospective rating plan is operating in a manner consistent with this chapter or other Minnesota laws. If it is found that the operation is deficient or inconsistent with this chapter or other Minnesota laws the commissioner may order the association to take corrective action.

Subd. 6. **Deficits.** The association shall certify to the commissioner the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted and payment of the maximum final premium for all policyholders of the association. Within 60 days after the certification, the commissioner shall authorize the association to recover the members' respective shares of the deficit by assessing all members an amount sufficient to fully fund the obligations of the association. The assessment of each member shall be determined in the manner provided in section 62I.07. An assessment made pursuant to this section shall be deductible by the member from past or future premium taxes due the state.

Subd. 7. **Amendments to rating plan.** In addition to the usual manner of amending the rating plan set forth in this section and section 62I.05, the following procedure may also be used:

(1) Any person may, by written petition served upon the commissioner of commerce request that a hearing be held to amend the rating plan, or any part of the rating plan.

(2) The commissioner shall forward a copy of the petition to the chief administrative law judge within three business days of its receipt. The chief administrative law judge shall, within three business days of receipt of the copy of the petition or a request for hearing by the commissioner, set a hearing date, assign an administrative law judge to hear the matter, and notify the commissioner of the hearing date and the administrative law judge assigned to hear the matter. The hearing date must be set not less than 60 days nor more than 90 days from the date of receipt of the petition by the commissioner or the date of the commissioner's request for hearing if the commissioner is the person requesting a hearing.

(3) The commissioner shall publish a notice of the hearing in the State Register at least 30 days before the hearing date. The notice should be similar to that used for rulemaking under the administrative procedure act. Approval of the notice by the administrative law judge is not required.

(4) The hearing and all matters which occur after the hearing are a contested case under chapter 14. Within 45 days from the commencement of the hearing and within 15 days of the completion of the hearing the administrative law judge shall submit a report to the commissioner of commerce. The parties, or the administrative law judge, if the parties cannot agree, shall adjust all time requirements under the contested case procedure to conform with the 45-day requirement.

(5) The commissioner shall render a decision within ten business days of the receipt of the administrative law judge's report.

(6) If all parties to the proceeding agree, any of the previous requirements may be waived or modified.

(7) A petition for a hearing to amend the rating plan or any part of the rating plan received by the commissioner within 180 days of the date of the commissioner's decision in a prior proceeding to amend the rating plan is invalid and requires no action provided the petition involves the same rates as the previous hearing. If the petition involves matters in addition to those dealt with in the previous hearing, then the additional matters shall be treated as a separate petition for hearing and a hearing may be held on those matters.

History: *1986 c 455 s 25*

62I.07 MEMBERSHIP ASSESSMENTS.

Each member of the association shall participate in its losses and expenses in the proportion that the direct written premiums of the member bears to the total aggregate

direct written premiums written in this state by all members. The members' participation in the association shall be determined annually on the direct written premiums written during the preceding calendar year as reported on the annual statements and other reports filed by the member with the commissioner.

History: *1986 c 455 s 26*

62I.08 APPLICATION PROCEDURE.

A person or entity that has been denied coverage or is unable to find an insurer willing to write coverage is eligible to make an application to the association. The application shall be on a form approved by the board of directors. To show eligibility to participate in the association the applicant shall certify that the applicant has been unable to find anyone to offer the coverage sought by the applicant. No further proof shall be required of the applicant. The application shall be filed simultaneously with the association and the market assistance plan of the association.

History: *1986 c 455 s 27*

62I.09 MARKET ASSISTANCE PLAN.

Subdivision 1. **Creation.** A market assistance program committee consisting of 12 members is created. The 12 members shall be appointed by the commissioner of commerce. The commissioner's designated representative shall serve as an ex officio member. The commissioner shall appoint six members of the committee as representatives of insurers; two members who are insurance agents; two public members; and two members representative of groups to whom the association has issued coverage. If, at any time after appointment, a member of the committee, through change of employment or similar circumstances, is no longer representative of the group the member was appointed to represent, that member shall be deemed unable to continue to serve as a member of the committee and the commissioner shall appoint a replacement for the balance of that member's term.

Subd. 2. **Terms and vacancies.** In the event of a member's inability to continue to serve, the commissioner shall appoint a replacement. The committee shall elect a chair and vice-chair from among the members. The term of each member is one year commencing on June 1, except that the first members to be appointed to the committee shall serve from the date of their appointment until June 1 immediately following their appointment.

Subd. 3. **Meetings.** The committee shall convene upon the call of the commissioner, the chair or vice-chair or at the request of one of the committee members. No quorum requirements are necessary.

History: *1986 c 455 s 28*

62I.10 DISPOSITION OF APPLICATION.

Subdivision 1. **Action upon application.** Upon receipt of an application, the committee or persons the committee appoints or designates will immediately review the application to determine what assistance the committee can give. The assistance may include: (1) discussion with the applicant's most recent underwriter, if any, to determine if the applicant's coverage can be maintained with the most recent carrier; (2) discussion with other known available insurance markets to determine if any other carrier will accept the applicant; (3) negotiating extensions of coverage with the most recent carrier or a temporary carrier, if possible, to permit additional exploration of insurance markets or accumulation of essential underwriting data; and (4) referring the application to the first five participating insurers (participants) on the relevant list provided in subdivision 2. Subsequent applications will be sent to the next five participants on a rotating basis. If at any time there are less than ten participants on the master list then the master list will no longer be utilized.

Subd. 2. **List of participating insurers.** A list of participants shall be prepared and updated at least every two years in the following manner: (1) the committee will secure

a mailing list from the department of commerce of every licensed insurer admitted to do business as well as every eligible licensed surplus lines licensee; (2) the committee will mail to each admitted insurer and eligible surplus lines licensee an outline of the conditions of participation; (3) a master list of participants willing to take part in the market assistance program will be created from the responses to the initial mailing. The master list will be updated at least every two years pursuant to clauses (1) and (2). Order on the master list will be determined by random selection.

Subd. 3. **Referral to participants.** Upon receipt of an application, the committee or the persons the committee appoints or designates may mail or telex copies of the application to the first five participants on the master list.

Subd. 4. **Quotes.** Participants must quote on at least one out of every three applications submitted. Each participant will have the right to individually evaluate the risk the applicant poses and develop a price commensurate with that risk.

Subd. 5. **Referral.** If no quote is received from the first five participants on the list, the next five participants on the list shall receive the application and the same procedure shall be followed until a quote is obtained or the list is exhausted. All participants may, if the committee feels it appropriate, be given the application at once.

Subd. 6. **Response from participant.** Participants may provide a quote on the same coverage basis they normally provide for similar coverage for that type of insurance in Minnesota. Participants will return their quotations or refusals to quote to the committee within ten days. The applicant or the applicant's agent, if any, will be notified of the quotations. The agent will then complete the placement of the insurance, if the applicant accepts coverage from the participant at the price quoted, without need for an agency appointment from that participant. The insurer is not required to pay the agent any commission, but the agent may negotiate a fee with the applicant prior to initial submission of the application.

Subd. 7. **Limitation on reapplication.** An applicant provided a quotation in accordance with the above procedure will not be eligible to seek additional quotations from the market assistance plan or to obtain coverage from the association if the quotation received would not be deemed to be a notice of refusal for purposes of determining eligibility for participation in the association.

Subd. 8. **Review by the committee.** If the procedures in subdivisions 1 to 7 do not produce a quote, the application may be submitted to the committee. The committee after reviewing the application shall proceed as follows: (1) attempt to place the applicant with a single carrier; or (2) attempt to arrange coverage on a quota share basis with a number of carriers.

Subd. 9. **Disqualification after coverage granted.** If an application is filed with the market assistance program less than 30 business days before the expiration date of the applicant's current insurance coverage the market assistance program may continue to seek coverage for the applicant after coverage is extended by the association. The market assistance program will have 30 business days from the date of filing of the application with the market assistance program to obtain an offer of coverage for the applicant. If the market assistance program is able to secure an offer of coverage for the applicant within 30 business days of filing of the application and if the offer of coverage would not otherwise be considered a refusal for purposes of the association, the applicant will be deemed to not be qualified to participate in the association and coverage, if any, shall be terminated. If the applicant accepts the coverage obtained by the market assistance plan, coverage from the association will terminate when the new coverage begins.

Subd. 10. **Notification of failure to place.** If the market assistance program does not produce a quote, it shall notify the submitting agent or the applicant at least 24 hours before the time the applicant's current insurance coverage terminates. A copy of the notification must be submitted to the commissioner and the association at the same time notice is made to the agent or applicant. Notwithstanding the foregoing, the market assistance program may continue to act pursuant to subdivision 9. Notice that the market assistance program is continuing to act pursuant to subdivision 9 shall be included in the notice required by this subdivision.

History: *1986 c 455 s 29*

62I.11 PROGRAM PARTICIPATION.

Subdivision 1. **Termination.** A participant may terminate its participation in the program at any time by providing written notice of the termination 90 days in advance of the effective date of the termination to the commissioner and to the committee.

Subd. 2. **New participants.** New participants may join the program at any time by submitting a written request to the commissioner and to the committee.

History: *1986 c 455 s 30*

62I.12 [Repealed, 1989 c 260 s 25]

62I.121 BENEFITS FOR EMPLOYEES.

At the option of the board, employees may participate in the state retirement plan and the state deferred compensation plan for employees in the unclassified service, and an insurance plan administered by the commissioner of employee relations under chapter 43A.

History: *1992 c 564 art 1 s 44*

62I.13 ACTION BY THE MINNESOTA JOINT UNDERWRITING ASSOCIATION UPON THE APPLICATION.

Subdivision 1. **Generally.** Eligibility for coverage by the association is subject to the terms and conditions of subdivisions 2 and 3.

Subd. 2. **Minimum of qualifications.** Anyone who is unable to obtain insurance in the private market and who so certifies to the association in the application is eligible to make written application to the association for coverage. Payment of the applicable premium or required portion of it must be paid prior to coverage by the association. An offer of coverage at a rate in excess of the rate that would be charged by the association for similar coverage and risk shall be deemed to be a refusal of coverage for purposes of eligibility for participation in the association. It shall not be deemed to be a written notice of refusal if the rate for coverage offered is less than five percent in excess of the joint underwriting association rates for similar coverage and risk. However, the offered rate must also be the rate that the insurer has filed with the department of commerce if the insurer is required to file its rates with the department. If the insurer is not required to file its rates with the department, the offered rate must be the rate generally charged by the insurer for similar coverage and risk.

Subd. 3. **Disqualifying factors.** For good cause, coverage may be denied or terminated by the association. Good cause may exist if the applicant or insured: (1) has an outstanding debt due or owing to the association at the time of application or renewal arising from a prior policy; (2) refuses to permit completion of an audit requested by the commissioner or administrator; (3) submits misleading or erroneous information to the commissioner or administrator; (4) disregards safety standards, laws, rules or ordinance pertaining to the risk being insured; (5) fails to supply information requested by the commissioner or administrator; (6) fails to comply with the terms of the policies or contracts for coverage issued by the association; and (7) has not satisfied the requirements of the market assistance program as set forth in section 62I.09.

Subd. 4. **Disqualification after coverage granted.** If an application is filed with the market assistance program less than 30 business days before the expiration of the applicant's current insurance coverage, the market assistance program may continue to seek coverage for the applicant after coverage is extended by the association. The market assistance program will have 30 business days from the date of filing the application with the market assistance program to obtain an offer of coverage for the applicant. If the market assistance program is able to secure an offer of coverage for the applicant within 30 business days of filing of the application and if the offer of coverage would not otherwise be considered refusal for purposes of the association, the applicant will be deemed to be not qualified to participate in the association plan and coverage, if any, shall be terminated.

Subd. 5. **Notice.** An application for coverage under the association must be granted or denied within ten days after receipt by the administrator of a properly completed application and any supplemental information requested by the administrator. Anyone covered by the association must be given at least 30 days notice of nonrenewal or cancellation of coverage.

Subd. 6. Notwithstanding any order of the commissioner or inconsistent provisions of this chapter, the board of directors may decline to offer coverage to any class of business or a member of a class of business upon a reasonable underwriting basis.

History: *1986 c 455 s 32; 1987 c 337 s 82*

62I.14 ASSESSMENTS.

In the event the commissioner deems it necessary to make an assessment, an assessed insurer must pay the assessment within 30 days of receipt of notice of the assessment. The commissioner may suspend or revoke an insurer's certificate of authority and impose a civil penalty in an amount not to exceed $5,000 for an insurer's failure to pay the assessment within the 30-day period.

History: *1986 c 455 s 33*

62I.15 EXTENSION OF COVERAGE.

If the association determines that the applicant meets the underwriting standards of the association as described in the plan of operation and there is no unpaid, uncontested premium due from the application for prior insurance, including failure to make written objections to premium charges within 30 days after billing, or if there is no other allowable reason as set forth in this chapter for denial of coverage, the association upon receipt of the premium or portion of it as described in the plan of operation shall issue a policy of insurance to the applicant.

History: *1986 c 455 s 34*

62I.16 STABILIZATION RESERVE FUND.

Subdivision 1. **Creation.** There is created a stabilization reserve fund. Each policyholder shall pay to the association a stabilization reserve fund charge of 33 percent of each premium payment due for insurance through the association. This charge shall be separately stated in the policy. The association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge.

Subd. 2. **Payment.** The association shall promptly pay into the stabilization reserve fund all fund charges it collects from its policyholders and any retrospective premium refunds payable under the group retrospective rating plan.

Subd. 3. **Supervision.** All money paid into the fund shall be held in escrow by the escrow administrator selected by the board of directors. The escrow administrator may invest the money held in escrow subject to the approval of the board. All investment income shall be credited to the fund. All expenses of the administration of the fund shall be charged against the fund. The money held in escrow shall be used solely for the purpose of discharging when due any retrospective premium charges payable by policyholders and any retrospective premium refunds payable to policyholders under the group retrospective rating plan. Payment of retrospective premium charges shall be made upon certification of the amount due. If all money accruing to the fund is exhausted in payment of retrospective premium charges, all liability and obligations of the association's policyholders with respect to the payment of retrospective premium charges shall terminate and shall be conclusively presumed to have been discharged. Any stabilization reserve fund charges from a particular policy year not used to pay retrospective premiums must be returned to policyholders after all claims and expense obligations from that particular policy year are satisfied.

Subd. 4. **Exemption.** The board of directors may, upon their own motion or upon application of any applicant or insured, exempt any group from the payment of the stabilization reserve charge. The exemption shall be granted only to those groups who are

unable to obtain insurance coverage in the private market as a result of the private market's refusal to write coverage for that group rather than because of loss experiences or risks posed by the applicant or insured as an individual. It shall be presumed that a group is qualified for this exemption if more than 20 percent of the members of that group are unable to obtain the insurance coverage that they seek. The board of directors shall also consider granting exemption if any members of the same group are unable to obtain coverage in the private market even though no claims have been made against them or payments made on their behalf by any insurer within the last three years.

Subd. 5. **Surcharge.** In addition to determining the basic rate for coverages to be offered by the joint underwriting association, the association shall also develop a surcharge plan or similar method for adjusting the rate to be charged to those persons who have had claims made against them. The surcharge plan shall take into effect the risk posed to the association by the applicant or the insured. The surcharge plan shall be sufficient to provide for the sound financial operation of the plan based upon commonly agreed upon actuarial principles.

History: *1986 c 455 s 35; 1987 c 337 s 83; 1989 c 260 s 8*

62I.17 IMMUNITY FROM LIABILITY.

No cause of action of any nature shall arise against the association, the commissioner or the commissioner's authorized representatives, or any other person or organization, for any statements made in good faith by them during any proceedings or concerning any matters within the scope of this chapter.

History: *1986 c 455 s 36*

62I.18 RIGHT OF APPEAL.

Any applicant to the association, any person insured pursuant to this chapter or their representatives, any affected insurer, or any person who has applied for coverage pursuant to this chapter may appeal to the commissioner within 30 days after any ruling, action, or decision by or on behalf of the association with respect to those items that the plan of operation defines as appealable matters.

History: *1986 c 455 s 37*

62I.19 ANNUAL STATEMENTS.

On March 1 of each year the association shall file with the commissioner a report of its transactions, financial conditions, and operations during the preceding year. The report shall be on a form approved by the commissioner. The commissioner may at any time require the association to furnish additional information to assist in evaluating the scope, operation, and experience of the association.

History: *1986 c 455 s 38*

62I.20 MERGER OF OTHER PLANS.

Upon application by the governing body of the liquor liability assigned risk plan authorized by section 340A.409 or the joint underwriting association authorized by chapter 62F to be merged with the association, the commissioner shall, if the commissioner deems it appropriate, hold a public hearing in regard to the merger. The commissioner upon motion or upon the motion of any insured under plans shall hold a hearing. Unless it can be shown that the rights of the insured would be adversely affected by the merger or that it would be less efficient or more costly to merge the plans, the commissioner shall consent to the merger. The commissioner shall also consent to the merger at any time there are less than ten insureds in any plan.

History: *1986 c 455 s 39*

621.21 ACTIVATION OF MARKET ASSISTANCE PLAN AND JOINT UNDERWRITING ASSOCIATION.

At any time the commissioner of commerce deems it necessary to provide assistance with respect to the placement of general liability insurance coverage on Minnesota risks for a class of business, the commissioner shall by notice in the State Register activate the market assistance plan and the joint underwriting association. The plan and association are activated for a period of 180 days from publication of the notice. At the same time the notice is published, the commissioner shall prepare a written petition requesting that a hearing be held to determine whether activation of the market assistance plan and the joint underwriting association is necessary beyond the 180-day period. The hearing must be held in accordance with section 621.22. The commissioner by order shall deactivate a market assistance program and the joint underwriting association at any time the commissioner finds that the market assistance program and the joint underwriting association are not necessary.

History: *1986 c 455 s 40*

621.22 HEARING.

Subdivision 1. **Administrative law judge.** The commissioner shall forward a copy of the petition to activate the market assistance plan and the joint underwriting association with respect to a class of business to the chief administrative law judge. The chief administrative law judge shall, within three business days of receipt of the copy of the petition, set a hearing date, assign an administrative law judge to hear the matter, and notify the commissioner of the hearing date and the administrative law judge assigned to hear the matter. The hearing date must be no less than 60 days nor more than 90 days from the date of receipt of the petition by the chief administrative law judge.

Subd. 2. **Notice.** The commissioner of commerce shall publish notice of the hearing in the State Register at least 30 days before the hearing date. The notice should be that used for rulemaking under chapter 14. Approval by the administrative law judge of the notice prior to publication is not required. The notice must contain a statement that anyone wishing to oppose activation beyond 180 days for any particular class, must file a petition to intervene with the administrative law judge at least ten days before the hearing date. If no notice to intervene is filed for a class, then the class is activated beyond the 180-day period without further action.

Subd. 3. **Contested case; report.** The hearing and all matters after the hearing are a contested case under chapter 14. Within 45 days from the commencement of the hearing and within 15 days of the completion of the hearing the administrative law judge shall submit a report to the commissioner of commerce. The parties, or the administrative law judge, if the parties cannot agree, shall adjust all time requirements under the contested case procedure to conform with the 45-day requirement.

Subd. 4. **Decision.** The commissioner shall make a decision within ten days of the receipt of the administrative law judge's report.

Subd. 5. **Waiver or modification.** If all parties to the proceeding agree, any of the requirements of this section may be waived or modified.

Subd. 6. **Case presentation.** The department of commerce, upon request by small businesses as defined by section 14.115, subdivision 1, shall assist small businesses in any specific class requesting continuation of coverage beyond the 180-day period, in coordinating the class and presenting the case in the contested hearing.

History: *1986 c 455 s 41; 1987 c 337 s 84,85*