CHAPTER 60A

GENERAL INSURANCE POWERS

60A.02 DEFINITIONS.

[For text of subds 1 to 28, see M.S.1994]

Subd. 29. **Multiple employer trust.** "Multiple employer trust" means a trust organized for the benefit of two or more employers for the purpose of providing health insurance coverage to employees and dependents.

History: *1995 c 234 art 7 s 1*

60A.03 COMMISSIONER OF COMMERCE.

[For text of subds 1 to 8, see M.S.1994]

Subd. 9. **Confidentiality of information.** The commissioner may not be required to divulge any information obtained in the course of the supervision of insurance companies, or the examination of insurance companies, including examination related correspondence and workpapers, until the examination report is finally accepted and issued by the commissioner, and then only in the form of the final public report of examinations. Nothing contained in this subdivision prevents or shall be construed as prohibiting the commissioner from disclosing the content of this information to the insurance department of another state or the National Association of Insurance Commissioners if the recipient of the information agrees in writing to hold it as nonpublic data as defined in section 13.02, in a manner consistent with this subdivision. This subdivision does not apply to the extent the commissioner is required or permitted by law, or ordered by a court of law to testify or produce evidence in a civil or criminal proceeding. For purposes of this subdivision, a subpoena is not an order of a court of law.

History: *1995 c 214 s 2*

60A.06 KINDS OF INSURANCE PERMITTED.

[For text of subds 1 and 2, see M.S.1994]

Subd. 3. **Limitation on combination policies.** (a) Unless specifically authorized by subdivision 1, clause (4), it is unlawful to combine in one policy coverage permitted by subdivision 1, clauses (4) and (5)(a). This subdivision does not prohibit the simultaneous sale of these products, but the sale must involve two separate and distinct policies.

(b) This subdivision does not apply to group policies.

(c) This subdivision does not apply to policies permitted by subdivision 1, clause (4), that contain benefits providing acceleration of life, endowment, or annuity benefits in advance of the time they would otherwise be payable, or to long–term care policies as defined in section 62A.46, subdivision 2.

History: *1995 c 258 s 1*

60A.07 AUTHORIZATION AND REQUIREMENTS.

[For text of subds 1 to 9, see M.S.1994]

Subd. 10. **Special provisions as to life companies.** (1) **Prerequisites of life companies.** No mutual life company shall be qualified to issue any policy until applications for at least $200,000 of insurance, upon lives of at least 200 separate residents, have been actually and in good faith made, accepted, and entered upon its books and at least one full annual premium thereunder, based upon the authorized table of mortality, received in cash or in absolutely payable and collectible notes. A duplicate receipt for each premium, conditioned for the return thereof unless the policy be issued within one year thereafter, shall be issued, and one copy delivered to the applicant and the other filed with the commissioner, together with the certificate of a solvent authorized bank in the state, of the deposit therein of such cash and notes, aggregating the amount aforesaid, specifying the maker, payee, date, maturity, and amount of each. Such cash and notes shall be held by it not longer than one year, and at or before the expiration thereof to be by it paid or delivered, upon the written order of the commissioner, to such company or applicants, respectively.

(2) **Foreign companies may become domestic.** Any company organized under the laws of any other state or country, which might have been originally incorporated under the laws of this state, and which has been admitted to do business therein for either or both the purpose of life or accident insurance, upon complying with all the requirements of law relative to the execution, filing, recording and publishing of original certificates and payment of incorporation fees by like domestic corporations, therein designating its principal place of business at a place in this state, may become a domestic corporation, and be entitled to like certificates of its corporate existence and license to transact business in this state, and be subject in all respects to the authority and jurisdiction thereof.

(3) **Temporary capital stock of mutual life companies.** A new mutual life insurance company which has complied with the provisions of clause (1) or an existing mutual life insurance company may establish, a temporary capital of, such amount not less than $100,000, as may be approved by the commissioner. Such temporary capital shall be invested by the company in the same manner as is provided for the investment of its other funds. Out of the net surplus of the company the holders of the temporary capital stock may receive a dividend which may be cumulative. This capital stock shall not be a liability of the company but shall be retired within a reasonable time and according to terms approved by the commissioner. At the time for the retirement of this capital stock, the holders shall be entitled to receive from the company the par value thereof and any dividends thereon due and unpaid, and thereupon the stock shall be surrendered and canceled. In the event of the liquidation of the company, the holders of temporary capital stock shall have the same preference in the assets of the company as shareholders have in a stock insurance company. Dividends on this stock are subject to section 60D.20, subdivision 2.

Temporary capital stock may be issued with or without voting rights. If issued with voting rights, the holders shall, at all meetings, be entitled to one vote for each $10 of temporary capital stock held.

[For text of subd 11, see M.S.1994]

History: *1995 c 214 s 3*

60A.085 CANCELLATION OF GROUP COVERAGE; NOTIFICATION TO COVERED PERSONS.

(a) No cancellation of any group life, group accidental death and dismemberment, group disability income, or group medical expense policy, plan, or contract regulated under chapter 62A or 62C is effective unless the insurer has made a good faith effort to notify all covered persons of the cancellation at least 30 days before the effective cancellation date. For purposes of this section, an insurer has made a good faith effort to notify all covered persons if the insurer has notified all the persons included on the list required by paragraph (b) at the home address given and only if the list has been updated within the last 12 months.

(b) At the time of the application for coverage subject to paragraph (a), the insurer shall obtain an accurate list of the names and home addresses of all persons to be covered.

(c) Paragraph (a) does not apply if the group policy, plan, or contract is replaced, or if the insurer has reasonable evidence to indicate that it will be replaced, by a substantially similar policy, plan, or contract.

(d) In no event shall this section extend coverage under a group policy, plan, or contract more than 120 days beyond the date coverage would otherwise cancel based on the terms of the group policy, plan, or contract.

(e) If coverage under the group policy, plan, or contract is extended by this section, then the time period during which affected members may exercise any conversion privilege provided for in the group policy, plan, or contract is extended for the same length of time, plus 30 days.

History: *1995 c 258 s 2*

60A.093 REDUCTION FROM LIABILITY FOR REINSURANCE CEDED BY A DOMESTIC INSURER TO AN ASSUMING INSURER.

[For text of subd 1, see M.S.1994]

Subd. 2. **Letters of credit continued acceptance.** Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation must continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever comes first.

The letter of credit of an institution failing the standards of subdivision 1, clause (3) continues to be acceptable for no more than 30 days.

History: *1995 c 214 s 4*

60A.11 INVESTMENTS FOR DOMESTIC COMPANIES.

[For text of subds 1 to 17, see M.S.1994]

Subd. 18. **Stocks and limited partnerships.** (a) Stocks issued or guaranteed by any corporation incorporated under the laws of the United States of America or any state, commonwealth, or territory of the United States, including the District of Columbia, or the laws of the Dominion of Canada or any province or territory of Canada, or stocks or stock equivalents, including American Depository Receipts or unit investment trusts, listed or regularly traded on a national securities exchange on the following conditions:

(1) A company may not invest more than a total of 25 percent of its total admitted assets in stocks, stock equivalents, and convertible issues. Not more than ten percent of a company's total admitted assets may be invested in stocks, stock equivalents, and convertible issues not traded or listed on a national securities exchange or designated or approved for designation upon notice of issuance on the NASDAQ/National Market System. This limitation does not apply to investments under clause (4);

(2) A company may not invest in more than two percent of its total admitted assets in preferred stocks of any corporation which are traded on a national securities exchange and

may also invest in other preferred stocks if the issuer has qualified net earnings and if current or cumulative dividends are not then in arrears;

(3) A company may not invest in more than two percent of its total admitted assets in common stocks, common stock equivalents, or securities convertible into common stock or common stock equivalents of any corporation or business trust which are traded on a national securities exchange or designated or approved for designation upon notice of issuance on the NASDAQ/National Market System, and may also invest in other common stocks, stock equivalents, and convertible issues subject to the limitations specified in clause (1);

(4) A company may organize or acquire and hold voting control of a corporation or business trust through its ownership of common stock, common stock equivalents, or other securities, provided the corporation or business trust is: (a) a corporation providing investment advisory, banking, management or sale services to an investment company or to an insurance company, (b) a data processing or computer service company, (c) a mortgage loan corporation engaged in the business of making, originating, purchasing or otherwise acquiring or investing in, and servicing or selling or otherwise disposing of loans secured by mortgages on real property, (d) a corporation if its business is owning and managing or leasing personal property, (e) a corporation providing securities underwriting services or acting as a securities broker or dealer, (f) a real property holding, developing, managing, brokerage or leasing corporation, (g) any domestic or foreign insurance company, (h) any alien insurance company, if the organization or acquisition and the holding of the company is subject to the prior approval of the commissioner of commerce, which approval must be given upon good cause shown and is deemed to have been given if the commissioner does not disapprove of the organization or acquisition within 30 days after notification by the company, (i) an investment subsidiary to acquire and hold investments which the company could acquire and hold directly, if the investments of the subsidiary are considered direct investments for purposes of this chapter and are subject to the same percentage limitations, requirements and restrictions as are contained herein, or (j) any corporation whose business has been approved by the commissioner as complementary or supplementary to the business of the company. A company may invest up to an aggregate of ten percent of its total admitted assets under subclauses (a) to (e) of this clause. The diversification requirement of subdivision 12, paragraph (b), does not apply to this clause;

(5) A company may invest in warrants and rights granted by an issuer to purchase securities of the issuer if that security of the issuer, at the time of the acquisition of the warrant or right to purchase, would qualify as an investment under paragraph (a), clause (2) or (3), whichever is applicable, provided that security meets the standards prescribed in the clause at the time of acquisition of the securities; and

(6)(i) A company may invest in the securities of any face amount certificate company, unit investment trust, or management type investment company, registered or in the process of registration under the Investment Company Act of 1940 as from time to time amended, provided that the aggregate of all these investments other than in securities of money market mutual funds or mutual funds investing primarily in United States government securities, determined at cost, shall not exceed five percent of its total admitted assets; investments may be made under this clause without regard to the percentage limitations applicable to investments in voting securities.

(ii) A company may invest in any proportion of the shares or investment units of an investment company or investment trust, whether or not registered under the Investment Company Act of 1940, which is managed by an insurance company, member bank, trust company regulated by state or federal authority or an investment manager or adviser registered under the Investment Advisers Act of 1940 or qualified to manage the investments of an investment company registered under the Investment Company Act of 1940, provided that the investments of the investment company or investment trust are qualified investments made under this section and that the articles of incorporation, bylaws, trust agreement, investment management agreement, or some other governing instrument limits its investments to investments qualified under this section.

(b) A company may invest in or otherwise acquire and hold a limited partnership interest in any limited partnership formed under the laws of any state, commonwealth, or territory of the United States or under the laws of the United States of America. A company may invest

in or otherwise acquire and hold a member interest in any limited liability company formed under the laws of any state, commonwealth, or territory of the United States or under the laws of the United States. No limited partnership or limited liability company member interest shall be acquired if the investment, valued at cost, exceeds two percent of the admitted assets of the company or if the investment, plus the book value on the date of the investment of all limited partnership and limited liability company interests then held by the company and held under the authority of this subdivision, exceeds ten percent of the company's admitted assets. Limited partnership and limited liability company interests traded on a national securities exchange must be classified as stock equivalents and are not subject to the percentage limitations contained in this paragraph.

[For text of subd 19, see M.S.1994]

Subd. 20. **Real estate.** (a) Except as provided in paragraphs (b) to (d), a company may only acquire, hold, and convey real estate which:

(1) has been mortgaged to it in good faith by way of security for loans previously contracted, or for money due;

(2) has been conveyed to it in satisfaction of debts previously contracted in the course of its dealings;

(3) has been purchased at sales on judgments, decrees or mortgages obtained or made for the debts; and

(4) is subject to a contract for deed under which the company holds the vendor's interest to secure the payments the vendee is required to make thereunder.

All the real estate specified in clauses (1) to (3) must be sold and disposed of within five years after the company has acquired title to it, or within five years after it has ceased to be necessary for the accommodation of the company's business, and the company must not hold this property for a longer period unless the company elects to hold the real estate under another section, or unless it procures a certificate from the commissioner of commerce that its interest will suffer materially by the forced sale thereof, in which event the time for the sale may be extended to the time the commissioner directs in the certificate. The market value of real estate specified in clauses (1) to (3) must be established by the written certification of a licensed real estate appraiser. The appraisal is required at the time the company elects to hold the real estate under clauses (1) to (3).

(b) A company may acquire and hold real estate for the convenient accommodation of its business.

(c) A company may acquire real estate or any interest in real estate, including oil and gas and other mineral interests, as an investment for the production of income, and may hold, improve or otherwise develop, subdivide, lease, sell and convey real estate so acquired directly or as a joint venture or through a limited, limited liability, or general partnership in which the company is a partner or through a limited liability company in which the company is a member.

(d) A company may also hold real estate (1) if the purpose of the acquisition is to enhance the sale value of real estate previously acquired and held by the company under this section, and (2) if the company expects the real estate so acquired to qualify under paragraph (b) or (c) above within five years after acquisition.

(e) A company may, after securing the approval of the commissioner, acquire and hold real estate for the purpose of providing necessary living quarters for its employees. The company must dispose of the real estate within five years after it has ceased to be necessary for that purpose unless the commissioner agrees to extend the holding period upon application by the company.

(f) A company may not invest more than 25 percent of its total admitted assets in real estate. The cost of any parcel of real estate held for both the accommodation of business and for the production of income must be allocated between the two uses annually. No more than ten percent of a company's total admitted assets may be invested in real estate held under paragraph (b). No more than 15 percent of a company's total admitted assets may be invested in real estate held under paragraph (c). No more than three percent of its total admitted assets may be invested in real estate held under paragraph (e). Upon application by a company, the commissioner of commerce may increase any of these limits up to an additional five percent.

[For text of subds 21 to 26, see M.S.1994]

History: *1995 c 214 s 5,6*

60A.111 QUALIFIED ASSETS TO REQUIRED LIABILITIES; RATIO.

[For text of subd 1, see M.S.1994]

Subd. 2. **Plan.** If the commissioner determines that the required liabilities of any company are greater than its qualified assets and that the combined financial resources of the insurance company members of any insurance holding company system of which the company is a member are not adequate to counterbalance that fact, the commissioner may require the company to submit to the commissioner for approval a plan by which the company undertakes to bring the ratio of its qualified assets to its required liabilities, expressed as a percentage, up to at least 110 percent within a reasonable period, usually not exceeding five years.

[For text of subds 3 to 6, see M.S.1994]

History: *1995 c 258 s 3*

60A.124 INDEPENDENT AUDIT.

The audit report of the independent certified public accountant that performs the audit of an insurer's annual statement as required under section 60A.129, subdivision 3, paragraph (a), should contain a statement as to whether anything, in connection with their audit, came to their attention that caused them to believe that the insurer failed to adopt and consistently apply the valuation procedure as required by sections 60A.122 and 60A.123.

History: *1995 c 258 s 4*

60A.135 REPORT.

Subdivision 1. **Requirement.** Every insurer domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval, or information purposes pursuant to other provisions of law, rule, or other requirements.

Subd. 2. **Date due.** The report required in subdivision 1 is due within 15 days after the end of the calendar month in which the transactions occur.

Subd. 3. **Filing.** One complete copy of the report, including exhibits or other attachments filed as part of it, must be filed with the National Association of Insurance Commissioners.

Subd. 4. **Confidentiality.** Reports filed with the commissioner pursuant to sections 60A.135 to 60A.137 must be held as nonpublic data as defined in section 13.02, are not subject to subpoena, and may not be made public by the commissioner, the National Association of Insurance Commissioners, or other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains. However, the commissioner may publish all or part of a report in the manner the commissioner considers appropriate if, after giving the affected insurer notice and an opportunity to be heard, the commissioner determines that the interest of policyholders, shareholders, or the public will be served by the publication.

History: *1995 c 214 s 7*

60A.136 ACQUISITIONS AND DISPOSITIONS OF ASSETS.

Subdivision 1. **Materiality.** No acquisitions or dispositions of assets need be reported pursuant to section 60A.135 if the acquisitions or dispositions are not material. For purposes of sections 60A.135 to 60A.137, a material acquisition (or the aggregate of any series of related acquisitions during any 30–day period) or disposition (or the aggregate of any series of related dispositions during any 30–day period) is one that is nonrecurring and not in the ordi-

nary course of business and involves more than five percent of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the commissioner of commerce.

Subd. 2. **Scope.** (a) Asset acquisitions subject to sections 60A.135 to 60A.137 include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for this purpose.

(b) Asset dispositions subject to sections 60A.135 to 60A.137 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction, or other disposition.

Subd. 3. **Information to be reported.** (a) The following information is required to be disclosed in a report of a material acquisition or disposition of assets:

(1) date of the transaction;

(2) manner of acquisition or disposition;

(3) description of the assets involved;

(4) nature and amount of the consideration given or received;

(5) purpose of, or reason for, the transaction;

(6) manner by which the amount of consideration was determined;

(7) gain or loss recognized or realized by the insurer as a result of the transaction; and

(8) name of each person from whom the assets were acquired or to whom they were disposed.

(b) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

History: *1995 c 214 s 8*

60A.137 NONRENEWALS, CANCELLATIONS, OR REVISIONS OF CEDED REINSURANCE AGREEMENTS.

Subdivision 1. **Materiality.** (a) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported pursuant to section 60A.135 if the nonrenewals, cancellations, or revisions are not material. For purposes of sections 60A.135 to 60A.137, a material nonrenewal, cancellation, or revision for:

(1) property and casualty business, including accident and health business when written by a property and casualty insurer is one that affects:

(i) more than 50 percent of an insurer's ceded written premium; or

(ii) more than 50 percent of the insurer's total ceded indemnity and loss adjustment reserves; and

(2) life, annuity, and accident and health business, is one that affects more than 50 percent of the total reserve credit taken for business ceded, on an annualized basis as indicated in the insurer's most recently filed statutory statement.

(b) With respect to either property and casualty or life, annuity, and accident and health business, either of the following events constitute a material revision that must be reported under section 60A.135:

(1) an authorized reinsurer representing more than ten percent of a total cession is replaced by one or more unauthorized reinsurers; or

(2) previously established collateral requirements have been reduced or waived for one or more unauthorized reinsurers representing collectively more than ten percent of a total cession.

(c) Notwithstanding paragraphs (a) and (b), no filing is required:

(1) for property and casualty business, including accident and health business written by a property and casualty insurer if the insurer's total ceded written premium represents, on an annualized basis, less than ten percent of its total written premium for direct and assumed business; or

(2) for life, annuity, and accident and health business if the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of the statutory reserve requirement before any cession.

Subd. 2. **Information to be reported.** (a) The following information is required to be disclosed in a report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(1) effective date of the nonrenewal, cancellation, or revision;

(2) the description of the transaction with an identification of the initiating entity;

(3) purpose of, or reason for, the transaction; and

(4) if applicable, the identity of the replacement reinsurers.

(b) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

History: *1995 c 214 s 9*

60A.15 TAXATION OF INSURANCE COMPANIES.

Subdivision 1. **Domestic and foreign companies.** (a) On or before April 1, June 1, and December 1 of each year, every domestic and foreign company, including town and farmers' mutual insurance companies, domestic mutual insurance companies, marine insurance companies, health maintenance organizations, integrated service networks, community integrated service networks, and nonprofit health service plan corporations, shall pay to the commissioner of revenue installments equal to one–third of the insurer's total estimated tax for the current year. Except as provided in paragraphs (d) and (e), installments must be based on a sum equal to two percent of the premiums described in paragraph (b).

(b) Installments under paragraph (a), (d), or (e) are percentages of gross premiums less return premiums on all direct business received by the insurer in this state, or by its agents for it, in cash or otherwise, during such year.

(c) Failure of a company to make payments of at least one–third of either (1) the total tax paid during the previous calendar year or (2) 80 percent of the actual tax for the current calendar year shall subject the company to the penalty and interest provided in this section, unless the total tax for the current tax year is $500 or less.

(d) For health maintenance organizations, nonprofit health services plan corporations, integrated service networks, and community integrated service networks, the installments must be based on an amount equal to one percent of premiums described in paragraph (b) that are paid after December 31, 1995.

(e) For purposes of computing installments for town and farmers' mutual insurance companies and for mutual property casualty companies with total assets on December 31, 1989, of $1,600,000,000 or less, the following rates apply:

(1) for all life insurance, two percent;

(2) for town and farmers' mutual insurance companies and for mutual property and casualty companies with total assets of $5,000,000 or less, on all other coverages, one percent; and

(3) for mutual property and casualty companies with total assets on December 31, 1989, of $1,600,000,000 or less, on all other coverages, 1.26 percent.

(f) Premiums under medical assistance, the MinnesotaCare program, and the Minnesota comprehensive health insurance plan are not subject to tax under this section.

[For text of subds 1a to 5, see M.S.1994]

Subd. 7. [Repealed, 1995 c 264 art 17 s 10]

[For text of subds 8 to 11, see M.S.1994]

Subd. 12. **Overpayments, claims for refund.** (1) **Procedure, time limit, appropriation.** A company who has paid, voluntarily or otherwise, or from whom there has been collected an amount of tax for any year in excess of the amount legally due for that year, may file with the commissioner of revenue a claim for a refund of the excess. Except as provided in subdivision 11, no claim or refund shall be allowed or made after the period prescribed in section 289A.40, subdivision 1. For this purpose, a return or amended return claiming an overpayment constitutes a claim for refund.

Upon the filing of a claim, the commissioner shall examine it, shall make and file written findings denying or allowing the claim in whole or in part, and shall mail a notice thereof to the company at the address stated upon the return. If the claim is allowed in whole or in part, the commissioner shall issue a certificate for the refundment of the excess paid by the company, with interest at the rate specified in section 270.76 computed from the date of the payment of the tax until the date the refund is paid or the credit is made to the company. The commissioner of finance shall pay the refund out of the proceeds of the taxes imposed by this section, as other state moneys are expended. As much of the proceeds of the taxes as necessary are appropriated for that purpose.

(2) **Denial of claim, court proceedings.** If the claim is denied in whole or in part, the commissioner shall mail an order of denial to the company in the manner prescribed in subdivision 8. An appeal from this order may be taken to the Minnesota tax court in the manner prescribed in section 271.06, or the company may commence an action against the commissioner to recover the denied overpayment. The action may be brought in the district court of the district in the county of its principal place of business, or in the district court for Ramsey county. The action in the district court must be commenced within 18 months following the mailing of the order of denial to the company. If a claim for refund is filed by a company and no order of denial is issued within six months of the filing, the company may commence an action in the district court as in the case of a denial, but the action must be commenced within two years of the date that the claim for refund was filed.

(3) **Consent to extend time.** If the commissioner and the company have, within the periods prescribed in clause (1), consented in writing to any extension of time for the assessment of the tax, the period within which a claim for refund may be filed, or a refund may be made or allowed, if no claim is filed, shall be the period within which the commissioner and the company have consented to an extension for the assessment of the tax and six months thereafter.

(4) **Overpayments; refunds.** If the amount determined to be an overpayment exceeds the taxes imposed by this section, the amount of excess shall be considered an overpayment. An amount paid as tax constitutes an overpayment even if in fact there was no tax liability with respect to which the amount was paid.

Notwithstanding any other provision of law to the contrary, in the case of any overpayment, the commissioner, within the applicable period of limitations, shall refund any balance of more than one dollar to the company if the company requests the refund.

[For text of subds 13 and 15, see M.S.1994]

History: *1995 c 264 art 9 s 3; art 13 s 1*

NOTE: The amendments to subdivision 12 by Laws 1995, chapter 264, article 13, section 1, are effective for claims for refund which have not been filed as of June 2, 1995, and in which the time period for filing the claim has not expired under the provisions in effect prior to June 2, 1995. The time period for filing such claims is the time period prescribed in subdivision 12, or one year after June 2, 1995, whichever is greater. See Laws 1995, chapter 264, article 13, section 24.

60A.178 LIFE OR HEALTH INSURANCE POLICY QUOTAS.

No insurer, its officers, or managers shall require licensed property and casualty agents to sell a specified number of life or health insurance policies or a specified dollar amount of

life and health insurance as a condition of selling property–casualty insurance. No insurer, its officers, or managers may reduce or restrict an agent's underwriting authority on property–casualty insurance policies based upon the sale of life or health insurance. The provisions of this section do not apply to agents who are directly employed by the insurer or who write 80 percent or more of their gross annual insurance business for one company or any or all of its subsidiaries.

History: *1995 c 152 s 1*

60A.199 EXAMINATIONS.

[For text of subds 1 to 7, see M.S.1994]

Subd. 8. **Refund procedure; time limit; appropriation.** A licensee which has paid, voluntarily or otherwise, or from which there was collected an amount of tax for any year in excess of the amount legally due for that year, may file with the commissioner of revenue a claim for a refund of the excess. Except as provided in subdivision 3, no claim or refund shall be allowed or made after the period prescribed in section 289A.40, subdivision 1. For this purpose, a return or amended return claiming an overpayment constitutes a claim for refund.

Upon the filing of a claim the commissioner shall examine it, shall make written findings thereon denying or allowing the claim in whole or in part, and shall mail a notice thereof to the licensee at the address stated upon the return. If the claim is allowed in whole or in part, the commissioner shall issue a certificate for a refund of the excess paid by the licensee, with interest at the rate specified in section 270.76 computed from the date of the payment of the tax until the date the refund is paid or credit is made to the licensee. The commissioner of finance shall cause the refund to be paid as other state moneys are expended. So much of the proceeds of the taxes as is necessary are appropriated for that purpose.

[For text of subd 9, see M.S.1994]

Subd. 10. **Consent to extend time.** If the commissioner and the licensee have, within the periods prescribed by this section, consented in writing to any extension of time for the assessment of the tax, the period within which a claim for refund may be filed, or a refund may be made or allowed, if no claim is filed, is the period within which the commissioner and the licensee have consented to an extension for the assessment of the tax and six months thereafter.

[For text of subd 11, see M.S.1994]

History: *1995 c 264 art 13 s 2,3*

NOTE: The amendment to subdivision 8 by Laws 1995, chapter 264, article 13, section 2, is effective for claims for refund which have not been filed as of June 2, 1995, and in which the time period for filing the claim has not expired under the provisions in effect prior to June 2, 1995. The time period for filing such claims is the time period prescribed in subdivision 8, or one year after June 2, 1995, whichever is greater. See Laws 1995, chapter 264, article 13, section 24.

60A.23 MISCELLANEOUS.

[For text of subds 1 to 6, see M.S.1994]

Subd. 8. **Self–insurance or insurance plan administrators who are vendors of risk management services.** (1) **Scope.** This subdivision applies to any vendor of risk management services and to any entity which administers, for compensation, a self–insurance or insurance plan. This subdivision does not apply (a) to an insurance company authorized to transact insurance in this state, as defined by section 60A.06, subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section 62D.02, subdivision 4; (d) to an employer directly operating a self–insurance plan for its employees' benefits; (e) to an entity which administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions; or (f) to an entity which administers a self–insurance or insurance plan if a licensed Minnesota insurer is providing insurance to the plan and if the licensed insurer has appointed the entity administering the plan as one of its licensed agents within this state.

(2) **Definitions.** For purposes of this subdivision the following terms have the meanings given them.

(a) "Administering a self–insurance or insurance plan" means (i) processing, reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii) otherwise providing necessary administrative services in connection with the operation of a self–insurance or insurance plan.

(b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

(c) "Entity" means any association, corporation, partnership, sole proprietorship, trust, or other business entity engaged in or transacting business in this state.

(d) "Self–insurance or insurance plan" means a plan providing life, medical or hospital care, accident, sickness or disability insurance for the benefit of employees or members of an association, or a plan providing liability coverage for any other risk or hazard, which is or is not directly insured or provided by a licensed insurer, service plan corporation, or health maintenance organization.

(e) "Vendor of risk management services" means an entity providing for compensation actuarial, financial management, accounting, legal or other services for the purpose of designing and establishing a self–insurance or insurance plan for an employer.

(3) **License.** No vendor of risk management services or entity administering a self–insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license may be granted only when the commissioner is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner may issue a license subject to restrictions or limitations upon the authorization, including the type of services which may be supplied or the activities which may be engaged in. The license fee is $100. All licenses are for a period of two years.

(4) **Regulatory restrictions; powers of the commissioner.** To assure that self–insurance or insurance plans are financially solvent, are administered in a fair and equitable fashion, and are processing claims and paying benefits in a prompt, fair, and honest manner, vendors of risk management services and entities administering insurance or self–insurance plans are subject to the supervision and examination by the commissioner. Vendors of risk management services, entities administering insurance or self–insurance plans, and insurance or self–insurance plans established or operated by them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu of an unlimited guarantee from a parent corporation for a vendor of risk management services or an entity administering insurance or self–insurance plans, the commissioner may accept a surety bond in a form satisfactory to the commissioner in an amount equal to 120 percent of the total amount of claims handled by the applicant in the prior year. If at any time the total amount of claims handled during a year exceeds the amount upon which the bond was calculated, the administrator shall immediately notify the commissioner. The commissioner may require that the bond be increased accordingly.

(5) **Rulemaking authority.** To carry out the purposes of this subdivision, the commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:

(a) establish reporting requirements for administrators of insurance or self–insurance plans;

(b) establish standards and guidelines to assure the adequacy of financing, reinsuring, and administration of insurance or self–insurance plans;

(c) establish bonding requirements or other provisions assuring the financial integrity of entities administering insurance or self–insurance plans; or

(d) establish other reasonable requirements to further the purposes of this subdivision.

History: *1995 c 233 art 2 s 56; 1995 c 258 s 5*

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

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

Subd. 2. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Attachment point" means the claims amount beyond which the insurance company or health carrier incurs a liability for payment.

(b) "Direct coverage" means coverage under which an insurance company or health 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 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; or

(2) has an aggregate attachment point that is lower than the sum 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.

(b) 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), on January 1 of any year, based upon changes in the medical component of the Consumer Price Index (CPI). Adjustments must be in increments of $100 and must not be made unless at least that amount of adjustment is required. The commissioner shall publish any change in these dollar amounts at least three months before their effective date.

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

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

(b) With respect to an employer who had been issued a policy or evidence of coverage denominated as stop loss coverage before June 2, 1995, compliance with this section is required as of the first renewal date occurring on or after June 2, 1995.

History: *1995 c 258 s 6*

60A.236 STOP LOSS REGULATION.

A contract providing stop loss coverage, issued or renewed to a small employer, as defined in section 62L.02, subdivision 26, or to a plan sponsored by a small employer, must include a claim settlement period no less favorable to the small employer or plan than coverage of all claims incurred during the contract period regardless of when the claims are paid.

History: *1995 c 258 s 7*

60A.26 SUSPENSION OF INSURERS; NOTIFICATIONS AND REPORTS.

Subdivision 1. **Other states.** The commissioner of commerce shall notify the insurance departments of all other states whenever, under any law then in effect, the commissioner suspends the right of a foreign or domestic insurer to transact business in this state.

Subd. 2. **NAIC.** The commissioner of commerce shall report public regulatory actions, investigative information, and complaints to the appropriate reporting system or database of the National Association of Insurance Commissioners.

History: *1995 c 258 s 8*

60A.32 RATE FILING FOR CROP HAIL INSURANCE.

An insurer issuing policies of insurance against crop damage by hail in this state shall file its insurance rates with the commissioner. The insurance rates must be filed before March 1 of the year in which a policy is issued.

History: *1995 c 24 s 1*

REGULATION OF RISK-BASED CAPITAL

60A.60 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 60A.60 to 60A.696, the terms defined in this section have the meanings given them.

Subd. 2. **Adjusted risk-based capital report.** "Adjusted risk-based capital report" means a risk-based capital report that has been adjusted by the commissioner according to section 60A.61, subdivision 5.

Subd. 3. **Corrective order.** "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

Subd. 4. **Domestic insurer.** "Domestic insurer" means an insurance company incorporated or organized in this state.

Subd. 5. **Foreign insurer.** "Foreign insurer" means an insurance company that is admitted to do business in this state under section 60A.19 but is not incorporated or organized in this state.

Subd. 6. **NAIC.** "NAIC" means the National Association of Insurance Commissioners.

Subd. 7. **Life and/or health insurer.** "Life and/or health insurer" means an insurance company authorized to transact business under section 60A.06, subdivision 1, clause (4), or a

property and casualty insurer transacting business only under section 60A.06, subdivision 1, clause (5)(a).

Subd. 8. **Property and casualty insurer.** "Property and casualty insurer" means an insurance company authorized to transact business under section 60A.06, subdivision 1, clauses (1), (2), (3), (5), (6), (8), (9), (10), (11), (12), (13), (14), and (15), but does not include monoline mortgage guaranty insurers, and financial guaranty insurers.

Subd. 9. **Negative trend.** "Negative trend" means, with respect to a life and/or health insurer, negative trend over a period of time, as determined according to the "trend test calculation" included in the risk–based capital instructions.

Subd. 10. **Risk–based capital instructions.** "Risk–based instructions" means the risk–based capital report including risk–based capital instructions adopted by the NAIC, as those risk–based instructions may be amended by the NAIC from time to time according to the procedures adopted by the NAIC.

Subd. 11. **Risk–based capital level.** "Risk–based capital level" means an insurer's company action level risk–based capital, regulatory action level risk–based capital, authorized control level risk–based capital, or mandatory control level risk–based capital where:

(1) "company action level risk–based capital" means, with respect to an insurer, the product of 2.0 and its authorized control level risk–based capital;

(2) "regulatory action level risk–based capital" means the product of 1.5 and its authorized control level risk–based capital;

(3) "authorized control level risk–based capital" means the number determined under the risk–based capital formula according to the risk–based capital instructions;

(4) "mandatory control level risk–based capital" means the product of .70 and the authorized control level risk–based capital.

Subd. 12. **Risk–based capital plan.** "Risk–based capital plan" means a comprehensive financial plan containing the elements specified in section 60A.62, subdivision 2. If the commissioner rejects the risk–based capital plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called the "revised risk–based capital plan."

Subd. 13. **Risk–based capital report.** "Risk–based capital report" means the report required in section 60A.61.

Subd. 14. **Total adjusted capital.** "Total adjusted capital" means the sum of:

(1) an insurer's statutory capital and surplus as determined in accordance with statutory accounting applicable to the annual statement required to be filed under section 60A.13; and

(2) other items, if any, as the risk–based capital instructions may provide.

History: *1995 c 253 s 2*

60A.61 RISK–BASED CAPITAL REPORTS.

Subdivision 1. **General requirements.** Every domestic insurer shall, on or before each March 1, prepare and submit to the commissioner a report of its risk–based capital levels as of the end of the calendar year just ended, in a form and containing the information required by the risk–based capital instructions. In addition, every domestic insurer shall file its risk–based capital report:

(1) with the NAIC according to the risk–based capital instructions; and

(2) with the insurance commissioner in a state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its risk–based capital report not later than the later of:

(i) 15 days from the receipt of notice to file its risk–based capital report with that state; or

(ii) March 1.

Subd. 2. **Life and/or health insurers.** A life and/or health insurer's risk–based capital must be determined according to the formula set forth in the risk–based capital instructions. The formula must take into account, and may adjust for the covariance between:

(1) the risk with respect to the insurer's assets;

(2) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) the interest rate risk with respect to the insurer's business; and

(4) all other business risks and other relevant risks set forth in the risk–based capital instructions;

determined in each case by applying the factors in the manner set forth in the risk–based capital instructions.

Subd. 3. **Property and casualty insurers.** A property and casualty insurer's risk–based capital must be determined according to the formula set forth in the risk–based capital instructions. The formula must take into account, and may adjust for the covariance between:

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and other relevant risks set forth in the risk–based capital instructions;

determined in each case by applying the factors in the manner set forth in the risk–based capital instructions.

Subd. 4. **Maintaining additional capital.** An excess of capital over the amount produced by the risk–based capital requirements contained in sections 60A.60 to 60A.696 and the formulas, schedules, and instructions referenced in sections 60A.60 to 60A.696 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the risk–based capital levels required by sections 60A.60 to 60A.696. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk–based capital requirements contained in sections 60A.60 to 60A.696.

Subd. 5. **Adjusted risk–based capital report.** If a domestic insurer files a risk–based capital report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the risk–based capital report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. A risk–based capital report as so adjusted is referred to as an "adjusted risk–based capital report."

History: *1995 c 253 s 3*

60A.62 COMPANY ACTION LEVEL EVENT.

Subdivision 1. **Definition.** "Company action level event" means any of the following events:

(1) the filing of a risk–based capital report by an insurer which indicates that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level risk–based capital but less than its company action level risk–based capital; or

(ii) if a life and/or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level risk–based capital but less than the product of its authorized control level risk–based capital and 2.5 and has a negative trend;

(2) the notification by the commissioner to the insurer of an adjusted risk–based capital report that indicates an event in clause (1), provided the insurer does not challenge the adjusted risk–based report under section 60A.66; or

(3) if, pursuant to section 60A.66, an insurer challenges an adjusted risk–based capital report that indicates the event in clause (1), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

Subd. 2. **Plan.** In the event of a company action level event, the insurer shall prepare and submit to the commissioner a risk–based capital plan that:

(1) identifies the conditions that contribute to the company action level event;

(2) contains proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the company action level event;

(3) provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projected statutory balance sheets, income

statements, and cash flow statements. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) identifies the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) identifies the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

Subd. 3. **Submission.** The risk–based capital plan must be submitted:

(1) within 45 days of the company action level event; or

(2) if the insurer challenges an adjusted risk–based capital report pursuant to section 60A.66, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

Subd. 4. **Notification by commissioner.** Within 60 days after the submission by an insurer of a risk–based capital plan to the commissioner, the commissioner shall notify the insurer whether the risk–based capital plan must be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the risk–based capital plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination, and may set forth proposed revisions that will render the risk–based capital plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised risk–based capital plan, that may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised risk–based capital plan to the commissioner:

(1) within 45 days after the notification from the commissioner; or

(2) if the insurer challenges the notification from the commissioner under section 60A.66, within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

Subd. 5. **Unsatisfactory plan.** In the event of a notification by the commissioner to an insurer that the insurer's risk–based capital plan or revised risk–based capital plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under section 60A.66, specify in the notification that the notification constitutes a regulatory action level event.

Subd. 6. **Filings to other states.** Every domestic insurer that files a risk–based capital plan or revised risk–based capital plan with the commissioner shall file a copy of the risk–based capital plan or revised risk–based capital plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) the state has a risk–based capital provision substantially similar to section 60A.67, subdivision 1; and

(2) the insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the risk–based capital plan or revised risk–based capital plan in that state no later than the later of:

(i) 15 days after the receipt of notice to file a copy of its risk–based capital plan or revised risk–based plan with the state; or

(ii) the date on which the risk–based capital plan or revised risk–based capital plan is filed under section 60A.62, subdivisions 3 and 4.

History: *1995 c 253 s 4*

60A.63 REGULATORY ACTION LEVEL EVENT.

Subdivision 1. **Definition.** "Regulatory action level event" means, with respect to an insurer, any of the following events:

(1) the filing of a risk–based capital report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level risk–based capital but less than its regulatory action level risk–based capital;

(2) the notification by the commissioner to an insurer of an adjusted risk–based capital report that indicates the event in clause (1), provided the insurer does not challenge the adjusted risk–based capital report under section 60A.66;

(3) if, pursuant to section 60A.66, the insurer challenges an adjusted risk–based capital report that indicates the event in clause (1), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(4) the failure of the insurer to file a risk–based capital report by March 1, unless the insurer has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten days after March 1;

(5) the failure of the insurer to submit a risk–based capital plan to the commissioner within the time period set forth in section 60A.62, subdivision 3;

(6) notification by the commissioner to the insurer that:

(i) the risk–based capital plan or revised risk–based capital plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under section 60A.66;

(7) if, pursuant to section 60A.66, the insurer challenges a determination by the commissioner under clause (6), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge;

(8) notification by the commissioner to the insurer that the insurer has failed to adhere to its risk–based capital plan or revised risk–based capital plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event according to its risk–based capital plan or revised risk–based capital plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under section 60A.66; or

(9) if, pursuant to section 60A.66, the insurer challenges a determination by the commissioner under clause (8), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge.

Subd. 2. **Commissioner's duties.** In the event of a regulatory action level event, the commissioner shall:

(1) require the insurer to prepare and submit a risk–based capital plan, or, if applicable, a revised risk–based capital plan;

(2) examine or analyze as the commissioner considers necessary the assets, liabilities, and operations of the insurer including reviewing its risk–based capital plan or revised risk–based capital plan; and

(3) subsequent to the examination or analysis, issue a corrective order specifying the corrective actions the commissioner determines are required.

Subd. 3. **Corrective action.** In determining corrective actions, the commissioner may take into account factors considered relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the risk–based capital instructions. The risk–based capital plan or revised risk–based capital plan must be submitted:

(1) within 45 days after the occurrence of the regulatory action level event;

(2) if the insurer challenges an adjusted risk–based capital report pursuant to section 60A.66 and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(3) if the insurer challenges a revised risk–based capital plan pursuant to section 60A.66 and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

Subd. 4. **Examination and review.** The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the insurer's risk–based capital plan or revised risk–based capital plan, examine or

analyze the assets, liabilities, and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or other party as directed by the commissioner.

History: *1995 c 253 s 5*

60A.64 AUTHORIZED CONTROL LEVEL EVENT.

Subdivision 1. **Definition.** "Authorized control level event" means any of the following events:

(1) the filing of a risk–based capital report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level risk–based capital but less than its authorized control level risk–based capital;

(2) the notification by the commissioner to the insurer of an adjusted risk–based capital report that indicates the event in clause (1), provided the insurer does not challenge the adjusted risk–based capital report under section 60A.66;

(3) if, pursuant to section 60A.66, the insurer challenges an adjusted risk–based capital report that indicates the event in clause (1), notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(4) the failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the insurer has not challenged the corrective order under section 60A.66; or

(5) if the insurer has challenged a corrective order under section 60A.66 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

Subd. 2. **Commissioner's duties.** In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(1) take the actions required under section 60A.63 regarding an insurer with respect to which a regulatory action level event has occurred; or

(2) if the commissioner considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take the actions necessary to cause the insurer to be placed under regulatory control under chapter 60B. In the event the commissioner takes these actions, the authorized control level event is considered sufficient grounds for the commissioner to take action under chapter 60B, and the commissioner has the rights, powers, and duties with respect to the insurer set forth in chapter 60B. In the event the commissioner takes actions under this clause pursuant to an adjusted risk–based capital report, the insurer is entitled to the protections afforded to insurers under section 60B.11 pertaining to summary proceedings.

History: *1995 c 253 s 6*

60A.65 MANDATORY CONTROL LEVEL EVENT.

Subdivision 1. **Definition.** "Mandatory control level event" means any of the following events:

(1) the filing of a risk–based capital report that indicates that the insurer's total adjusted capital is less than its mandatory control level risk–based capital;

(2) notification by the commissioner to the insurer of an adjusted risk–based capital report that indicates the event in clause (1), provided the insurer does not challenge the adjusted risk–based capital report under section 60A.66; or

(3) if, pursuant to section 60A.66, the insurer challenges an adjusted risk–based capital report that indicates the event in clause (1), notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

Subd. 2. **Commissioner's duties.** In the event of a mandatory control level event:

(1) with respect to a life and/or health insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under chapter 60B. In that event, the mandatory control level event is considered sufficient grounds for the commissioner to take

action under chapter 60B, and the commissioner has the rights, powers, and duties with respect to the insurer set forth in chapter 60B. If the commissioner takes actions pursuant to an adjusted risk–based capital report, the insurer is entitled to the protections of section 60B.11 pertaining to summary proceedings. However, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90–day period; and

(2) with respect to a property and casualty insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under chapter 60B, or, in the case of an insurer that is writing no business and that is running off its existing business, may allow the insurer to continue its run–off under the supervision of the commissioner. In either event, the mandatory control level event is sufficient grounds for the commissioner to take action under chapter 60B, and the commissioner has the rights, powers, and duties with respect to the insurer set forth in chapter 60B. If the commissioner takes actions pursuant to an adjusted risk–based capital report, the insurer is entitled to the protections of section 60B.11 pertaining to summary proceedings. However, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90–day period.

History: *1995 c 253 s 7*

60A.66 HEARINGS.

Upon:

(1) notification to an insurer by the commissioner of an adjusted risk–based report;

(2) notification to an insurer by the commissioner that:

(i) the insurer's risk–based capital plan or revised risk–based capital plan is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer;

(3) notification to an insurer by the commissioner that the insurer has failed to adhere to its risk–based capital plan or revised risk–based capital plan and that the failure has substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer according to its risk–based capital plan or revised risk–based capital plan; or

(4) notification to an insurer by the commissioner of a corrective order with respect to the insurer,

the insurer has the right to a confidential hearing conducted in accordance with chapter 14, on a record, at which the insurer may challenge any determination or action by the commissioner. The insurer shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under clause (1), (2), (3), or (4). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing no less than ten nor more than 30 days after the date of the insurer's request.

History: *1995 c 253 s 8*

60A.67 CONFIDENTIALITY.

Subdivision 1. **Generally.** All risk–based capital reports, to the extent the information in them is not required to be set forth in a publicly available annual statement schedule, and risk–based capital plans, including the results or report of an examination or analysis of an insurer performed pursuant to sections 60A.60 to 60A.696, and any corrective order issued by the commissioner pursuant to an examination or analysis, with respect to a domestic insurer or foreign insurer that are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors, and shall be maintained by the commissioner as nonpublic data as defined in section 13.02, subdivision 9. This information is not subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to sections 60A.60 to 60A.696 or other provision of the insurance laws of this state.

Subd. 2. **Prohibition on announcements.** The comparison of an insurer's total adjusted capital to any of its risk–based capital levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Except as otherwise required under sections 60A.60 to 60A.696, the making, publishing, dissemination, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk–based capital levels of an insurer, or of any component derived in the calculation, by an insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is prohibited. However, if a materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its risk–based capital levels, or any of them, or an inappropriate comparison of any other amount to the insurer's risk–based capital levels is published in a written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Subd. 3. **Prohibition on use in ratemaking.** The risk–based capital instructions, risk–based capital reports, adjusted risk–based capital reports, risk–based capital plans, and revised risk–based capital plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers. This information shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in a rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for a line of insurance that an insurer or an affiliate is authorized to write.

History: *1995 c 253 s 9*

60A.68 SUPPLEMENTAL PROVISIONS; RULES; EXEMPTION.

(a) Sections 60A.60 to 60A.696 are supplemental to other laws of this state and do not preclude or limit other powers or duties of the commissioner under those laws, including, but not limited to, chapters 60B and 60G.

(b) The commissioner may exempt from the application of sections 60A.60 to 60A.696 a domestic property and casualty insurer that:

(1) writes direct business only in this state;

(2) writes direct annual premiums of $2,000,000 or less; and

(3) assumes no reinsurance in excess of five percent of direct premium written.

History: *1995 c 253 s 10*

60A.69 FOREIGN INSURERS.

Subdivision 1. **Reporting requirements.** A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner a risk–based capital report as of the end of the calendar year just ended not later than the later of:

(1) the date a risk–based capital report would be required to be filed by a domestic insurer under sections 60A.60 to 60A.696; or

(2) fifteen days after the request is received by the foreign insurer.

A foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner copies of all risk–based capital plans that are filed by the insurer with the insurance commissioners of other states.

Subd. 2. **A risk–based capital plan requirement.** In the event of a company action level event, regulatory action level event, or authorized control level event with respect to a foreign insurer as determined under the risk–based capital statute applicable in the state of domicile of the insurer, or, if no risk–based capital statute is in force in that state, under sections 60A.60 to 60A.696, if the insurance commissioner of the state of domicile of the foreign in-

surer fails to require the foreign insurer to file a risk–based capital plan in the manner specified under that state's risk–based capital statute, or, if no risk–based capital statute is in force in that state, under section 60A.62, the commissioner may require the foreign insurer to file a risk–based capital plan with the commissioner. In this event, the failure of the foreign insurer to file a risk–based capital plan with the commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state. This section does not limit the commissioner's authority to require a foreign insurer to file a copy of the risk–based capital plan submitted to the commissioner in the state of domicile.

Subd. 3. **Liquidation of property.** In the event of a mandatory control level event with respect to a foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to the district court permitted under chapter 60B with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event is adequate grounds for the application.

History: *1995 c 253 s 11*

60A.695 IMMUNITY.

There is no liability on the part of, and no cause of action arises against, the commissioner or the commerce department or its employees or agents for an action taken by them in the performance of their powers and duties under sections 60A.60 to 60A.696.

History: *1995 c 253 s 12*

60A.696 NOTICES.

All notices by the commissioner to an insurer that may result in regulatory action under sections 60A.60 to 60A.696 are effective upon dispatch if transmitted by registered or certified mail, or in the case of other transmission is effective upon the insurer's receipt of the notice.

History: *1995 c 253 s 13*

60A.705 DEFINITIONS.

[For text of subds 1 to 7, see M.S.1994]

Subd. 8. **Reinsurance intermediary–manager.** "Reinsurance intermediary–manager" or "RM" means any person, firm, association, or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office, and acts as an agent for that reinsurer whether known as an RM, manager, or other similar term. However, the following persons are not considered an RM, with respect to that reinsurer, for the purposes of sections 60A.70 to 60A.756:

(1) an employee of the reinsurer;

(2) a United States manager of the United States branch of an alien reinsurer;

(3) an underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to the holding company act, and whose compensation is not based on the volume of premiums written; or

(4) the manager of a group, association, pool, or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

[For text of subds 9 to 11, see M.S.1994]

History: *1995 c 214 s 10*

60A.715 REQUIRED CONTRACT PROVISIONS; REINSURANCE INTERMEDIARY–BROKERS.

Transactions between a RB and the insurer it represents in this capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization must, at a minimum, provide that:

(1) the insurer may terminate the RB's authority at any time;

(2) the RB will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to the RB, and remit all funds due to the insurer within 30 days of receipt;

(3) all funds collected for the insurer's account will be held by the RB in a fiduciary capacity in a bank that is a qualified United States financial institution and may be invested in direct obligations of, or obligations guaranteed or insured by, the United States, its agencies, or its instrumentalities, excluding mortgage–backed securities. These funds may not be invested in obligations whose maturities exceed 90 days;

(4) the RB will comply with section 60A.72;

(5) the RB will comply with the written standards established by the insurer for the cession or retrocession of all risks; and

(6) the RB will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

History: *1995 c 163 s 1*

60A.73 REQUIRED CONTRACT PROVISIONS; REINSURANCE INTERMEDIARY–MANAGERS.

[For text of subds 1 to 3, see M.S.1994]

Subd. 4. **Handling of funds.** All funds collected for the reinsurer's account will be held by the RM in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein and may be invested in direct obligations of, or obligations guaranteed or insured by, the United States, its agencies, or its instrumentalities, excluding mortgage–backed securities. These funds may not be invested in obligations whose maturities exceed 90 days. The RM may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate account for each reinsurer that it represents.

[For text of subds 5 to 15, see M.S.1994]

History: *1995 c 163 s 2*

60A.75 VIOLATIONS.

Subdivision 1. **Administrative and civil penalties and liabilities.** A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing conducted in accordance with chapter 14, to be in violation of any provision of sections 60A.70 to 60A.756, shall:

(1) for each separate violation, pay a penalty in an amount not exceeding $5,000; and

(2) be subject to revocation or suspension of its license.

Subd. 2. **Civil remedies.** (a) If it was found that because of the violation the insurer or reinsurer has suffered loss or damage, the commissioner may maintain a civil action for recovery of compensatory damages for the benefit of the reinsurer or insurer and its policyholders and creditors or seek other appropriate relief.

(b) If an order of rehabilitation or liquidation of the insurer has been entered pursuant to chapter 60B, and the receiver appointed under that order determines that the reinsurance intermediary or any other person has violated sections 60A.70 to 60A.756, or any rule or order adopted under those sections, and the insurer suffered any loss or damage, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

Subd. 3. **Judicial review.** The decision, determination, or order of the commissioner pursuant to subdivision 1 is subject to judicial review pursuant to chapter 14.

Subd. 4. **Other penalties.** Nothing contained in this section affects the right of the commissioner to impose any other penalties provided in the insurance laws.

History: *1995 c 214 s 11*

60A.951 DEFINITIONS.

[For text of subd 1, see M.S.1994]

Subd. 2. **Authorized person.** "Authorized person" means the county attorney, sheriff, or chief of police responsible for investigations in the county where the suspected insurance fraud occurred; the superintendent of the bureau of criminal apprehension; the commissioner of commerce; the commissioner of labor and industry; the attorney general; or any duly constituted criminal investigative department or agency of the United States.

[For text of subds 3 and 4, see M.S.1994]

Subd. 5. **Insurer.** "Insurer" means insurance company, risk retention group as defined in section 60E.02, service plan corporation as defined in section 62C.02, health maintenance organization as defined in section 62D.02, integrated service network as defined in section 62N.02, fraternal benefit society regulated under chapter 64B, township mutual company regulated under chapter 67A, joint self–insurance plan or multiple employer trust regulated under chapter 60F, 62H, or section 471.617, subdivision 2, persons administering a self–insurance plan as defined in section 60A.23, subdivision 8, clause (2), paragraphs (a) and (d), and the workers' compensation reinsurance association established in section 79.34.

[For text of subd 6, see M.S.1994]

History: *1995 c 258 s 9,10*

60A.954 INSURANCE ANTIFRAUD PLAN.

Subdivision 1. **Establishment.** An insurer shall institute, implement, and maintain an antifraud plan. For the purpose of this section, the term insurer does not include reinsurers, the workers' compensation reinsurance association, self–insurers, and excess insurers. Within 30 days after instituting or modifying an antifraud plan, the insurer shall notify the commissioner in writing. The notice must include the name of the person responsible for administering the plan. An antifraud plan shall establish procedures to:

(1) prevent insurance fraud, including: internal fraud involving the insurer's officers, employees, or agents; fraud resulting from misrepresentations on applications for insurance; and claims fraud;

(2) report insurance fraud to appropriate law enforcement authorities; and

(3) cooperate with the prosecution of insurance fraud cases.

[For text of subd 2, see M.S.1994]

History: *1995 c 258 s 11*

60A.955 CLAIM FORMS TO CONTAIN FRAUD WARNING.

All insurance claim forms issued by an insurer for use in submitting a claim for payment or a claim for any other benefit pursuant to a policy shall clearly contain a warning substantially as follows: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime." An insurer may comply with this section by including the warning on an addendum attached to the claim form. The absence of the required warning does not constitute a defense in a prosecution for a violation of chapter 609 or any other chapter of Minnesota Statutes.

History: *1995 c 258 s 12*

60A.961 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 60A.961 to 60A.974, the definitions in this section have the meanings given them.

Subd. 2. **Person.** "Person" means a natural or artificial entity, including individuals, partnerships, associations, trusts, limited liability companies, or corporations.

Subd. 3. **Viatical settlement broker.** "Viatical settlement broker" means an individual, partnership, limited liability company, corporation, or other entity who or which for another

and for a fee, commission, or other valuable consideration, offers or advertises the availability of viatical settlements, introduces viators to viatical settlement providers, or offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers. "Viatical settlement broker" does not include an attorney, accountant, or financial planner retained to represent the viator whose compensation is not paid by the viatical settlement provider.

Subd. 4. **Viatical settlement contract.** "Viatical settlement contract" means a written agreement entered into between a viatical settlement provider and a person owning a life insurance policy or who owns or is covered under a group policy insuring the life of a person who has a catastrophic or life threatening illness or condition. The agreement must establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the policy owner's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider.

Subd. 5. **Viatical settlement provider.** "Viatical settlement provider" means an individual, partnership, limited liability company, corporation, or other entity that enters into an agreement with a person owning a life insurance policy or who owns or is covered under a group policy insuring the life of a person who has a catastrophic or life threatening illness or condition, under the terms of which the viatical settlement provider pays compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the policy owner's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider. Viatical settlement provider does not include:

(1) a bank, savings bank, savings association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

(2) the issuer of a life insurance policy providing accelerated benefits under section 61A.072; or

(3) a natural person who enters into no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit.

Subd. 6. **Viator.** "Viator" means the owner or certificate holder of a life insurance policy insuring the life of a person with a catastrophic or life threatening illness or condition who enters into an agreement under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider.

History: *1995 c 151 s 2*

60A.962 LICENSE REQUIREMENTS.

Subdivision 1. **License.** No individual, partnership, limited liability company, corporation, or other entity may act as a viatical settlement provider or enter into or solicit a viatical settlement contract without first having obtained a license from the commissioner of commerce.

Subd. 2. **Form.** An applicant for a viatical settlement provider license shall submit an application to the commissioner of commerce on a form prescribed by the commissioner.

Subd. 3. **Contents.** The applicant shall provide information that the commissioner requires on forms prepared by the commissioner. The commissioner may, at any time, require the applicant to fully disclose the identity of all shareholders, members, partners, officers, and employees. The commissioner may, in the exercise of discretion, refuse to issue a license in the name of a firm, partnership, limited liability company, or corporation if not satisfied that an officer, employee, shareholder, member, or partner who may materially influence the applicant's conduct meets the requirements of sections 60A.961 to 60A.974.

Subd. 4. **Named persons.** A license issued to a partnership, limited liability company, corporation, or other entity authorizes all members, officers, partners, and designated employees to act as viatical settlement providers under the license, and all those persons must be named in the application and any supplements to the application.

Subd. 5. **Investigation.** Upon the filing of an application and the payment of the license fee, the commissioner shall investigate each applicant and may issue a license if the commissioner finds that the applicant:

(1) has provided a detailed plan of operation;

(2) is competent and trustworthy and intends to act in good faith in the capacity involved in the license applied for;

(3) has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied for; and

(4) if a corporation is a corporation incorporated under the laws of this state or a foreign corporation authorized to transact business in this state.

History: *1995 c 151 s 3*

60A.963 SERVICE OF PROCESS; NONRESIDENT LICENSING.

Subdivision 1. **License.** A nonresident of this state may be licensed as a viatical settlement provider upon compliance with all provisions of sections 60A.961 to 60A.974.

Subd. 2. **Service of process.** Section 45.028 applies to service of process upon a viatical settlement provider.

History: *1995 c 151 s 4*

60A.964 FEES.

Subdivision 1. **Amount.** The licensing fee for a viatical settlement provider license is $750 for initial licensure and $250 for each annual renewal. The commissioner may adjust the fees as provided under section 16A.1285 to recover the costs of administration and enforcement. The fees must be limited to the cost of license administration and enforcement and must be deposited in the state treasury, credited to a special account, and appropriated to the commissioner.

Subd. 2. **Automatic revocation.** A license is automatically revoked for failure to pay the licensing fee within the terms prescribed by the commissioner.

History: *1995 c 151 s 5*

60A.965 LICENSE REVOCATION.

Subdivision 1. **Revocation.** The commissioner may suspend, revoke, or refuse to renew the license of a viatical settlement provider if the commissioner finds that:

(1) there was any misrepresentation in the application for the license;

(2) the holder of the license has been found guilty of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent to act as a viatical settlement provider;

(3) the licensee demonstrates a pattern of unreasonable payments to policy owners;

(4) the licensee has been convicted of a felony or a misdemeanor of which criminal fraud is an element; or

(5) the licensee has violated any of the provisions of sections 60A.961 to 60A.974.

Subd. 2. **Administrative action.** Section 45.027 applies to any action taken by the commissioner in connection with the administration of sections 60A.961 to 60A.974.

History: *1995 c 151 s 6*

60A.966 APPROVAL OF VIATICAL SETTLEMENTS CONTRACTS.

A viatical settlement provider may not use a viatical settlement contract form in this state unless it has been filed with and approved by the commissioner. A viatical settlement contract form filed with the commissioner is considered to have been approved if it has not been disapproved within 60 days of the filing. The commissioner shall disapprove a viatical settlement contract form if, in the commissioner's opinion, the contract or contract provisions are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the policy owner.

History: *1995 c 151 s 7*

60A.967 REPORTING REQUIREMENTS.

Each licensee shall file with the commissioner on or before March 1 of each year an annual statement containing the following information for the previous calendar year:

(1) for each policy viaticated, the date that the viatical settlement was entered into; the life expectancy of the viator at the time of the contract; the face amount of the policy; the amount paid by the viatical settlement provider to viaticate the policy; and if the viator has died, the date of death and the total insurance premiums paid by the viatical settlement provider to maintain the policy in force;

(2) a breakdown of applications received, accepted, and rejected, by disease category;

(3) a breakdown of policies viaticated by issuer and policy type;

(4) the number of secondary market versus primary market transactions;

(5) the portfolio size; and

(6) the amount of outside borrowings.

History: *1995 c 151 s 8*

60A.968 EXAMINATION.

Subdivision 1. **Authorization.** The commissioner may, when the commissioner considers it reasonably necessary to protect the interests of the public, examine the business and affairs of a licensee or applicant for a license. The commissioner may order a licensee or applicant to produce records, books, files, or other information reasonably necessary to determine whether or not the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The licensee or applicant shall pay the expenses incurred in conducting an examination.

Subd. 2. **Private data.** Names and individual identification data for all viators is private and confidential information and must not be disclosed by the commissioner, unless required by law.

Subd. 3. **Records.** The licensee shall maintain records of all transactions of viatical settlement contracts and shall make them available to the commissioner for inspection during reasonable business hours.

History: *1995 c 151 s 9*

60A.969 DISCLOSURE.

A viatical settlement provider shall disclose the following information to the viator no later than the date the viatical settlement contract is signed by all parties:

(1) possible alternatives to viatical settlement contracts for persons with catastrophic or life threatening illnesses, including accelerated benefits offered by the issuer of the life insurance policy;

(2) the fact that some or all of the proceeds of the viatical settlement may be taxable and that assistance should be sought from a personal tax advisor;

(3) the fact that the viatical settlement may be subject to the claims of creditors;

(4) the fact that receipt of a viatical settlement may adversely effect the recipients' eligibility for Medicaid or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

(5) the policy owner's right to rescind a viatical settlement contract within 30 days of the date it is executed by all parties or 15 days of the receipt of the viatical settlement proceeds by the viator, whichever is less, as provided in section 60A.970, subdivision 3; and

(6) the date by which the funds will be available to the viator and the source of the funds.

History: *1995 c 151 s 10*

60A.970 GENERAL REQUIREMENTS.

Subdivision 1. **Required documents.** A viatical settlement provider entering into a viatical settlement contract with a person with a catastrophic or life threatening illness or condition shall first obtain:

(1) a written statement from a licensed attending physician that the person is of sound mind and under no constraint or undue influence; and

(2) a witnessed document in which the person consents to the viatical settlement contract, acknowledges the catastrophic or life threatening illness, represents that the person has a full and complete understanding of the viatical settlement contract, acknowledges that the person has a full and complete understanding of the benefits of the life insurance policy, releases the person's medical records, and acknowledges that the person has entered into the viatical settlement contract freely and voluntarily.

Subd. 2. **Confidentiality of medical information.** All medical information solicited or obtained by a licensee is subject to the applicable provisions of state law relating to confidentiality of medical information.

Subd. 3. **Unconditional refund provision.** All viatical settlement contracts entered into in this state must contain an unconditional refund provision of at least 30 days from the date that the viator signs an agreement to transfer an insurance policy or 15 days of the receipt of the viatical settlement proceeds, whichever is less.

Subd. 4. **Payment of proceeds.** Immediately upon receipt from the viator of documents to effect the transfer of the insurance policy, the viatical settlement provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a bank approved by the commissioner, pending acknowledgment of the transfer by the issuer of the policy. The trustee or escrow agent must transfer the proceeds due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer. Payment of the proceeds must be made by means of wire transfer to the viator or by certified check or cashier's check.

Subd. 5. **Lump sum payment.** Payment of the proceeds under a viatical settlement must be made in a lump sum. Retention of a portion of the proceeds by the viatical settlement provider or escrow agent is not permissible. Payment must not be made by installments unless the viatical settlement company has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank.

Subd. 6. **Additional payment.** With respect to policies containing a provision for double or other additional indemnity for accidental death, the additional payment must remain payable to the beneficiary last named by the viator before entering into the viatical settlement agreement, or to a beneficiary designated by the viator, other than the viatical settlement provider, or in the absence of a designation, to the estate of the viator.

Subd. 7. **Prohibited payments.** A viatical settlement provider or broker must not pay or offer to pay a finder's fee, commission, or other compensation to a viator's physician, attorney, accountant, or other person providing medical, legal, or financial planning services to the viator, or to any other person acting as an agent of the viator with respect to the viatical settlement.

Subd. 8. **Discrimination prohibited.** A viatical settlement provider or broker must not discriminate in the making of viatical settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status, or sexual orientation, or discriminate between viators with dependents and without.

Subd. 9. **Health status contacts.** Contacts for the purpose of determining the health status of the viator by the viatical settlement provider or broker after the viatical settlement has occurred must not exceed one every three months for viators with a life expectancy of more than one year and must not exceed one per month for viators with a life expectancy of one year or less. The provider or broker must explain the procedure for these contacts at the time the viatical settlement contract is entered into.

Subd. 10. **Prohibited investor solicitation.** Viatical settlement providers and brokers shall not solicit investors who may influence the treatment of the illness of the viators whose coverage is the subject of the investment.

Subd. 11. **Contract null and void.** Failure to tender the viatical settlement by the date disclosed to the viator renders the contract null and void.

History: *1995 c 151 s 11*

60A.971 STANDARDS FOR EVALUATIONS OF REASONABLE PAYMENTS.

In order to assure that viators receive a reasonable return for viaticating an insurance policy, the following are the minimum permitted discounts:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	80%
At least 6 but less than 12 months	70%
At least 12 but less than 18 months	65%
At least 18 but less than 24 months	60%
Twenty–four months or more	50%

The percentage may be reduced by five percent for viaticating a policy written by an insurer rated lower than the highest four categories by A.M. Best, or a comparable rating by another rating agency.

History: *1995 c 151 s 12*

60A.972 VIATICAL SETTLEMENT BROKERS.

Subdivision 1. **License.** A viatical settlement broker may not solicit a viatical settlement contract without first obtaining a license from the commissioner of commerce.

Subd. 2. **Form.** An applicant for a viatical settlement broker license shall submit an application to the commissioner on a form prescribed by the commissioner.

Subd. 3. **Fees.** The licensing fee for a viatical settlement broker is $750 for initial licensure and $250 for each annual renewal. Failure to pay the renewal fee within the time required by the commissioner results in an automatic revocation of the license. The commissioner may adjust the fees as provided under section 16A.1285 to recover the costs of administration and enforcement. The fees must be limited to the cost of license administration and enforcement and must be deposited in the state treasury, credited to a special account, and appropriated to the commissioner.

Subd. 4. **License limitation.** The license is a limited license which allows solicitation only of viatical settlements.

Subd. 5. **License revocation.** The commissioner may suspend, revoke, or refuse to renew the license of a viatical settlement broker if the commissioner finds that:

(1) there was any misrepresentation in the application for a license;

(2) the broker has been found guilty of fraudulent or dishonest practices, has been found guilty of a felony or a misdemeanor of which criminal fraud is an element, or is otherwise shown to be untrustworthy or incompetent;

(3) the licensee has placed or attempted to place a viatical settlement with a viatical settlement provider not licensed in this state; or

(4) the licensee has violated any of the provisions of sections 60A.961 to 60A.974.

Subd. 6. **Agent.** In the absence of a written agreement making the broker the viator's agent, viatical settlement brokers are presumed to be agents of viatical settlement providers.

Subd. 7. **Compensation prohibited.** A viatical settlement broker must not, without the written agreement of the viator obtained before performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

History: *1995 c 151 s 13*

60A.973 ADVERTISING STANDARDS.

Subdivision 1. **Generally.** Advertising by viatical settlement providers or brokers must be truthful and not misleading by fact or implication.

Subd. 2. **Average time.** If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

Subd. 3. **Average purchase price.** If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase prices as a percent of face value obtained by viators contracting with the advertiser during the previous six months.

History: *1995 c 151 s 14*

60A.974 UNFAIR TRADE PRACTICES.

A violation of sections 60A.961 to 60A.974 is an unfair trade practice under chapter 72A.

History: *1995 c 151 s 15*