CHAPTER 61B

LIFE AND HEALTH GUARANTY ASSOCIATION

61B.18 CITATION.
61B.19 PURPOSE; SCOPE; LIMITATION OF COVERAGE; LIMITATION OF BENEFITS; CONSTRUCTION.
61B.20 DEFINITIONS.
61B.21 MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.
61B.22 BOARD OF DIRECTORS.
61B.23 POWERS AND DUTIES OF ASSOCIATION.
61B.24 ASSESSMENTS.
61B.25 PLAN OF OPERATION.
61B.26 DUTIES AND POWERS OF COMMISSIONER.
61B.27 PREVENTION OF INSOLVENCIES.
61B.28 MISCELLANEOUS PROVISIONS.
61B.29 EXAMINATION; ANNUAL REPORT.
61B.30 TAX EXEMPTIONS.
61B.31 INDEMNIFICATION.
61B.32 STAY OF PROCEEDINGS; REOPENING DEFAULT JUDGMENTS.
61B.33 RIGHTS AND OBLIGATIONS OF ASSOCIATION.

61B.01 [Repealed, 1993 c 319 s 20]

61B.02 [Repealed, 1993 c 319 s 20]

61B.03 [Repealed, 1993 c 319 s 20]

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61B.10 [Repealed, 1993 c 319 s 20]

61B.11 [Repealed, 1993 c 319 s 20]

61B.12 [Repealed, 1993 c 319 s 20]

61B.13 [Repealed, 1993 c 319 s 20]

61B.14 [Repealed, 1993 c 319 s 20]

61B.15 [Repealed, 1993 c 319 s 20]

61B.16 [Repealed, 1993 c 319 s 20]

61B.18 CITATION.

Sections 61B.18 to 61B.32 may be cited as the "Minnesota Life and Health Insurance Guaranty Association Act."

History: *1993 c 319 s 3*

61B.19 PURPOSE; SCOPE; LIMITATION OF COVERAGE; LIMITATION OF BENEFITS; CONSTRUCTION.

Subdivision 1. **Purpose.** (a) The purpose of sections 61B.18 to 61B.32 is to protect, subject to certain limitations, the persons specified in subdivision 2 against failure in the performance of contractual obligations under life, health, and annuity policies or contracts, and the supplemental contracts specified in subdivision 2, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(b) To provide this protection, an association of member insurers has been created and exists to pay benefits and to continue coverages, as limited in sections 61B.18 to 61B.32. Members of the association are subject to assessment to provide funds to carry out the purpose of sections 61B.18 to 61B.32.

Subd. 2. **Scope.** (a) Sections 61B.18 to 61B.32 provide coverage for the policies and contracts specified in paragraph (b) to:

(1) persons who are owners, certificate holders, or enrollees under these policies or contracts, or, (i) in the case of unallocated annuity contracts, to the persons who are participants in a covered retirement plan, or (ii) in the case of structured settlement annuities, to persons who are payees in respect of their liability claims (or beneficiaries of such payees who are deceased) and who:

(A) are residents; or

(B) are not residents, but only under all of the following conditions: the member insurers that issued the policies or contracts are domiciled in the state of Minnesota; those insurers never held a license or certificate of authority in the states in which those persons reside; those states have associations similar to the association created by sections 61B.18 to 61B.32; and those persons are not eligible for coverage by those associations; and

(2) persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under clause (1). This includes health care providers rendering services covered by a health insurance policy or contract.

(b) Sections 61B.18 to 61B.32 provide coverage to the persons specified in paragraph (a) for direct, nongroup life insurance, health insurance, annuity, and supplemental policies or contracts, for subscriber contracts issued by a nonprofit health service plan corporation operating under chapter 62C, for health maintenance contracts issued by a health maintenance organization under chapter 62D, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by sections 61B.18 to 61B.32. Except as expressly excluded under subdivision 3, annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts. Covered unallocated annuity contracts include those that fund a qualified defined contribution retirement plan under sections 401, 403(b), and 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992.

Subd. 3. **Limitation of coverage.** Sections 61B.18 to 61B.32 do not provide coverage for:

(1) a portion of a policy or contract not guaranteed by the member insurer, or under which the investment risk is borne by the policy or contract holder;

(2) a policy or contract of reinsurance, unless assumption certificates have been issued and the insured has consented to the assumption as provided under section 60A.09, subdivision 4a;

(3) a policy or contract issued by an assessment benefit association operating under section 61A.39, or a fraternal benefit society operating under chapter 64B;

(4) any obligation to nonresident participants of a covered retirement plan or to the plan sponsor, employer, trustee, or other party who owns the contract; in these cases, the association is obligated under this chapter only to participants in a covered plan who are residents of the state of Minnesota on the date of impairment or insolvency;

(5) a structured settlement annuity in situations where a liability insurer remains liable to the payee;

(6) a portion of an unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a governmental lottery, including but not limited to, a contract issued to, or purchased at the direction of, any governmental bonding authority, such as a municipal guaranteed investment contract;

(7) a portion of a policy or contract issued to a plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

(i) a multiple employer welfare arrangement as defined in the Employee Retirement Income Security Act of 1974, United States Code, title 29, section 1002(40)(A), as amended;

(ii) a minimum premium group insurance plan;

(iii) a stop-loss group insurance plan; or

(iv) an administrative services only contract;

(8) any policy or contract issued by an insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(9) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(10) a portion of a policy or contract to the extent that it provides for (i) dividends or experience rating credits except to the extent the dividends or experience rating credits have actually become due and payable or have been credited to the policy or contract before the date of impairment or insolvency, (ii) voting rights, or (iii) payment of any fees or allowances to any person, including the policy or contract holder, in connection with the service to, or administration of, the policy or contract;

(11) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(12) a portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract, employed in calculating returns or changes in value:

(i) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under sections 61B.18 to 61B.32, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average

averaged for that same four-year period or for the lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under sections 61B.18 to 61B.32, whichever is earlier; and

(ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(iii) however, this paragraph shall not apply to a contract, policy, or rider for long-term care or health insurance;

(13) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 61B.18 to 61B.32, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and not subject to forfeiture under this clause, the interest or changes in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(14) a portion of a policy or contract to the extent that the assessments required by section 61B.24 with respect to the policy or contract are preempted by federal or state law;

(15) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to United States Code, title 42, chapter 7, subchapter XVIII, Part C or Part D, commonly known as Medicare Part C & D, or United States Code, title 42, chapter 7, subchapter XIX, commonly known as Medicaid, or any regulations issued under those provisions; and

(16) structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction, as defined in United States Code, title 26, section 5891, regardless of whether the transaction occurred before or after the effective date of section 5891.

Subd. 4. **Limitation of benefits.** The benefits for which the association may become liable shall in no event exceed the lesser of:

(1) the contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) subject to the limitation in clause (5), with respect to any one life, regardless of the number of policies or contracts:

(i) $500,000 in life insurance death benefits, but not more than $130,000 in net cash surrender and net cash withdrawal values for life insurance;

(ii) $500,000 in health insurance, long-term care, and disability income insurance benefits, including any net cash surrender and net cash withdrawal values;

(iii) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(iv) $410,000 in present value of annuity benefits for structured settlement annuities or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period

certain of not less than ten years, have begun to be paid, on or before the date of impairment or insolvency; or

(3) subject to the limitations in clauses (5) and (6), with respect to each individual resident participating in a retirement plan, except a defined benefit plan, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in net cash surrender and net cash withdrawal values;

(4) where no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value;

(5) in no event shall the association be liable to cover more than $500,000 in benefits in the aggregate with respect to any one life under clause (2), items (i), (ii), (iii), (iv), and clause (4), and any one individual under clause (3);

(6) in no event shall the association be liable to cover more than $10,000,000 in benefits with respect to all unallocated annuities of a retirement plan, except a defined benefit plan, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992. If total claims from a plan exceed $10,000,000, the $10,000,000 shall be prorated among the claimants;

(7) for purposes of applying clause (2)(ii) and clause (5), with respect only to health insurance benefits, the term "any one life" applies to each individual covered by a health insurance policy or contract;

(8) where covered contractual obligations are equal to or less than the limits stated in this subdivision, the association will pay the difference between the covered contractual obligations and the amount credited by the estate of the insolvent or impaired insurer, if that amount has been determined or, if it has not, the covered contractual limit, subject to the association's right of subrogation;

(9) where covered contractual obligations exceed the limits stated in this subdivision, the amount payable by the association will be determined as though the covered contractual obligations were equal to those limits. In making the determination, the estate shall be deemed to have credited the covered person the same amount as the estate would credit a covered person with contractual obligations equal to those limits; or

(10) the following illustrates how the principles stated in clauses (8) and (9) apply. The example illustrated concerns hypothetical claims subject to the limit stated in clause (2)(iii). The principles stated in clauses (8) and (9), and illustrated in this clause, apply to claims subject to any limits stated in this subdivision.

CONTRACTUAL OBLIGATIONS OF:

$100,000

	Estate	Guaranty Association
0% recovery from estate	$ 0	$100,000
25% recovery from estate	$25,000	$75,000
50% recovery from estate	$50,000	$50,000
75% recovery from estate	$75,000	$25,000

$250,000

	Estate	Guaranty Association
0% recovery from estate	$ 0	$250,000
25% recovery from estate	$62,500	$187,500
50% recovery from estate	$125,000	$125,000
75% recovery from estate	$187,500	$62,500

$300,000

	Estate	Guaranty Association
0% recovery from estate	$ 0	$250,000
25% recovery from estate	$75,000	$187,500
50% recovery from estate	$150,000	$125,000
75% recovery from estate	$225,000	$62,500

Subd. 5. **Limited liability.** The liability of the association is strictly limited by the express terms of the covered policies and contracts and by the provisions of sections 61B.18 to 61B.32 and is not affected by the contents of any brochures, illustrations, advertisements, or oral statements by agents, brokers, or others used or made in connection with their sale. This limitation on liability does not prevent an insured from proving liability that is greater than the express terms of the covered policy or contract. The insured must bring an action to claim the greater liability no later than one year after entry of an order of rehabilitation, conservation, or liquidation. The association is not liable for any extra-contractual claims, such as claims relating to bad faith in payment of claims and claims relating to marketing practices, exemplary, or punitive damages. The association is not liable for attorney fees or interest other than as provided for by the terms of the policies or contracts, subject to the other limits of sections 61B.18 to 61B.32.

Subd. 6. [Repealed, 2009 c 37 art 3 s 25]

Subd. 7. **Construction.** (a) Sections 61B.18 to 61B.32 shall be liberally construed to effect the purpose of sections 61B.18 to 61B.32. Subdivision 1 is an aid and guide to interpretation.

(b) Participants in an employer-sponsored plan, which is funded in whole or in part by a covered policy, as specified in subdivision 4, clause (3), shall only be required to verify their status as residents and the amount of money in the unallocated annuity that represents their funds. Both these matters may be verified by the employer sponsoring the plan from plan records. Payments made to a plan shall be deemed to be made on behalf of the resident participant and are not the funds of the plan, the plan trustee, or any nonresident plan participant, and to the extent of such payments, discharge the association's obligation.

History: *1993 c 319 s 4; 1994 c 426 s 11; 1999 c 177 s 36; 2001 c 142 s 1-4; 2009 c 37 art 3 s 15; 2010 c 275 art 1 s 10,11; 2020 c 80 art 2 s 2-5*

61B.20 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to sections 61B.18 to 61B.32.

Subd. 2. **Account.** "Account" means either of the two accounts created under section 61B.21, subdivision 1.

Subd. 3. **Annuity contracts.** "Annuity contracts" means annuity contracts as described in section 60A.06, subdivision 1, clause (4).

Subd. 4. **Association.** "Association" means the Minnesota Life and Health Insurance Guaranty Association.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 6. **Contractual obligation.** "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion of the policy or contract or certificate, for which coverage is provided under section 61B.19, subdivision 2.

Subd. 7. **Covered policy.** "Covered policy" means a policy or contract to which sections 61B.18 to 61B.32 apply, as provided in section 61B.19, subdivision 2.

Subd. 8. **Current contractual obligation.** "Current contractual obligation" means a contractual obligation which has become due and owing for: (1) death benefits; (2) health insurance benefits; (3) periodic annuity benefit or supplemental contract payments, provided the annuitant or payee elected the commencement of the periodic annuity benefit or supplemental contract payments before the date of impairment or insolvency, or if the annuitant or payee elected the commencement of the periodic annuity benefit or supplemental contract payments after the date of impairment or insolvency, (i) the election was made pursuant to a written plan, such as a retirement plan, which existed before the impairment or insolvency, or (ii) commencement of the periodic annuity benefit or supplemental contract payments was elected at or after the annuitant's attainment of age 65 and, in either case, was for a payment period of not less than the annuitant's lifetime or a period certain of not less than ten years; or (4) cash surrender or loan values or endowment proceeds or any portion thereof, but only if, and to the extent that, an emergency or hardship such as, but not limited to, the funds being reasonably necessary to pay education, medical, home purchase, or essential living expenses, is established in accordance with standards proposed by the association and approved by the commissioner. The hardship standards must also provide for an individual appeal to the board of directors in those circumstances which, while not meeting the standards approved by the commissioner, may truly be a hardship.

Subd. 9. **Direct life insurance.** "Direct life insurance" means life insurance as described in section 60A.06, subdivision 1, clause (4), and does not include credit life insurance regulated under chapter 62B.

Subd. 10. **Health insurance.** "Health insurance" means accident and health insurance as described in section 60A.06, subdivision 1, clause (5)(a), long-term care insurance as described in section 62A.46, subdivision 2, and chapter 62S, credit accident and health insurance regulated under chapter 62B, subscriber contracts issued by a nonprofit health service plan corporation operating under chapter 62C, and health maintenance contracts issued by a health maintenance organization operating under chapter 62D.

Subd. 11. **Impaired insurer.** "Impaired insurer" means a member insurer that is not an insolvent insurer, and:

(1) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction. The order of rehabilitation or conservation referred to in this subdivision is the initial order granting a petition, application, or other request to begin a rehabilitation or conservatorship; or

(2) is determined by the commissioner to be potentially unable to fulfill its contractual obligations and the commissioner has notified the association of the determination.

Subd. 12. **Insolvent insurer.** "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency. The order of liquidation referred to in this subdivision is the initial order granting a petition, application, or other request to begin a liquidation.

Subd. 13. **Member insurer.** "Member insurer" means an insurer or health maintenance organization licensed or holding a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under section 61B.19, subdivision 2, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. The term does not include:

(1) a nonprofit hospital or medical service organization, other than a nonprofit health service plan corporation that operates under chapter 62C;

(2) a fraternal benefit society;

(3) a mandatory state pooling plan;

(4) a mutual assessment company or an entity that operates on an assessment basis;

(5) an insurance exchange;

(6) a community integrated service network; or

(7) an entity similar to those listed in clauses (1) to (6).

Subd. 13a. **Moody's Corporate Bond Yield Average.** "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

Subd. 14. **Person.** "Person" means an individual, corporation, partnership, unincorporated association, limited liability company, governmental body or entity, or voluntary organization.

Subd. 15. **Premiums.** "Premiums" means amounts or considerations by whatever name called received on covered policies or contracts less premiums, considerations, and deposits returned, and less dividends and experience credits on those covered policies or contracts to the extent not guaranteed in advance. The term does not include amounts received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under section 61B.19, subdivision 3, except that assessable premium shall not be reduced on account of section 61B.19, subdivision 4, relating to limitations with respect to any one life, any one individual, and any one contract holder. Premiums subject to assessment under section 61B.24, include all amounts received on any unallocated annuity contract issued to a contract holder resident in this state if the contract is not otherwise excluded from coverage under section 61B.19, subdivision 3; provided that "premiums" shall not include any premiums in excess of the liability limit on any unallocated annuity contract specified in section 61B.19, subdivision 4.

Subd. 16. **Resident.** "Resident" means a person whose principal place of residence is Minnesota at the time a member insurer is initially determined by the commissioner or a court to be an impaired or insolvent insurer and to whom a contractual obligation is owed, whichever occurs first. A person may be a resident of only one state, which for a natural person is the person's principal place of residence, for a person other than a natural person is its principal place of business, and for a trust, is the principal place of business of the settlor or entity which established the trust. Citizens of the United States who are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories, or protectorates that do not have

an association similar to the association created by sections 61B.19 to 61B.32, are considered residents of this state if the insurer that issued the covered policies or contracts was domiciled in this state.

Subd. 16a. **State.** "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

Subd. 16b. **Structured settlement annuity.** "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

Subd. 17. **Supplemental contract.** "Supplemental contract" means a written agreement entered into for the distribution of policy or contract proceeds.

Subd. 18. **Unallocated annuity contract.** "Unallocated annuity contract" means an annuity contract, funding agreement, or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

History: *1993 c 319 s 5; 1994 c 625 art 8 s 3; 1996 c 446 art 2 s 10; 1997 c 225 art 2 s 62; 2001 c 142 s 5-13; 2003 c 19 s 1; 2020 c 80 art 2 s 6-8*

61B.21 MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.

Subdivision 1. **Functions.** The Minnesota Life and Health Insurance Guaranty Association shall perform its functions under the plan of operation established and approved under section 61B.25, and shall exercise its powers through a board of directors. The association is not a state agency for purposes of chapter 16A, 16B, 16C, or 43A. For purposes of administration and assessment, the association shall establish and maintain two accounts:

(1) the life insurance and annuity account which includes the following subaccounts:

(i) the life insurance account;

(ii) the annuity account; and

(iii) the unallocated annuity account; and

(2) the health account.

Subd. 2. **Supervision by commissioner of commerce.** The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state.

History: *1993 c 319 s 6; 1997 c 187 art 3 s 15; 1998 c 386 art 2 s 23; 2020 c 80 art 2 s 9*

61B.22 BOARD OF DIRECTORS.

Subdivision 1. **Members.** The board of directors of the association consists of nine member insurers serving terms as established in the plan of operation under section 61B.25. The insurer board members must be elected by member insurers, subject to the approval of the commissioner, for the terms of office specified in their nominations. Each elected insurer board member shall designate its representative and may designate an alternate. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to approval of the commissioner. In approving selections or in appointing insurer board members, the commissioner shall consider whether all member insurers are fairly represented.

Subd. 2. **Expenses.** Members of the board may be reimbursed from the assets of the association for reasonable and necessary expenses incurred by them as members of the board, but shall not otherwise be compensated by the association for their services.

Subd. 3. **Committees and meetings.** Except as otherwise required under the plan of operation:

(a) The board of directors may designate three or more directors as an executive committee, which, to the extent determined by unanimous affirmative action of the entire board, has and shall exercise the authority of the board in the management of the business of the association. This executive committee shall act only in the interval between meetings of the board, and is subject at all times to the control and direction of the board.

(b) The board of directors may create additional committees, which have and shall exercise the specific authority and responsibility as determined by the unanimous affirmative action of the entire board.

(c) Any action that may be taken at a meeting of the board of directors or of a lawfully constituted executive committee may be taken without a meeting if authorized by a writing or writings signed by all the directors or by all of the members of the committee, as the case may be. This action is effective on the date on which the last signature is placed on the writing or writings, or on an earlier effective date established in the writing or writings.

(d) Members of the board of directors or of a lawfully constituted executive committee may participate in a meeting of the board or committee by means of conference telephone or similar communications equipment through which all persons participating in the meeting can hear each other. Participation in a meeting as provided in this paragraph constitutes presence in person at the meeting.

Subd. 4. **Open meetings.** Board meetings are not subject to chapter 13D.

History: *1993 c 319 s 7; 2001 c 142 s 14; 2020 c 80 art 2 s 10*

61B.23 POWERS AND DUTIES OF ASSOCIATION.

Subdivision 1. **Impaired domestic insurer.** If a member insurer is an impaired domestic insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner, and that are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer;

(2) provide money, pledges, notes, guarantees, or other means as are proper to exercise the power granted in clause (1) and assure payment of the contractual obligations of the impaired insurer pending action under clause (1); or

(3) loan money to the impaired insurer.

Subd. 2. **Impaired insurer not paying claims.** (a) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims in a timely manner as required under section 72A.201, based in whole or in part on the insurer's financial inability to pay claims then subject to the preconditions specified in paragraph (b), the association shall, in its discretion, either:

(1) take any of the actions specified in subdivision 1, subject to the conditions in that subdivision; or

(2) provide for prompt payment of current contractual obligations.

(b) The association is subject to the requirements of paragraph (a) only if the commissioner has begun a formal administrative or judicial proceeding which seeks to suspend the authority of the impaired insurer to write new business in this state and to require the impaired insurer to cooperate with the association in the administration of claims. The suspension of the impaired insurer's authority to write new business in this state shall continue until all payments of or on account of the impaired insurer's contractual obligations paid by the association, along with all expenses thereof and interest on these payments and expenses, shall have been repaid to the association or a plan of repayment of the payments, expenses, and interest by the impaired insurer shall have been approved by the association. If the commissioner ceases to seek an administrative or judicial order suspending the impaired insurer's authority to write new business in this state within 90 days, or is denied the order, the association shall not be required to proceed under this subdivision unless:

(1) the impaired insurer has been placed under an order of rehabilitation or conservation by a court of competent jurisdiction; and

(2) the court has approved and entered an order providing that the rehabilitation or conservation proceedings shall not be dismissed, and neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management, and the impaired insurer is prohibited from soliciting or accepting new business or having a suspended or revoked license restored until at least one of the following events has occurred:

(i) all payments of or on account of the impaired insurer's contractual obligations paid by all the affected guaranty associations, along with expenses thereof and interest on all of those payments and expenses incurred by those guaranty associations, have been repaid to them; or

(ii) a plan of repayment by the impaired insurer has been approved by all the affected guaranty associations.

(c) The association shall endeavor to obtain access to those records of the impaired insured as are needed for the association to discharge its obligations and, if requested by the association, the commissioner will assist the association in obtaining access to those records. If the association is not given access to the necessary records, the association shall be relieved of its responsibility to make benefit payments until the time it is given access to those records.

(d) If the impaired insurer is subsequently determined to be insolvent by a court of competent jurisdiction in its state of domicile and is placed in liquidation, the association shall then proceed as provided in subdivision 3.

Subd. 3. **Insolvent insurer.** If a member insurer is an insolvent insurer then, subject to any conditions imposed by the association and approved by the commissioner, the association shall, in its discretion:

(1) guaranty, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer;

(2) assure payment of the contractual obligations of the insolvent insurer which are due and owing;

(3) provide money, pledges, guarantees, or other means as are reasonably necessary to discharge its duties; or

(4) provide benefits and coverages in accordance with subdivision 4.

Subd. 4. **Payments; alternative policies.** When proceeding under subdivision 2, paragraph (a), clause (2), or subdivision 3, clause (4), the association shall, with respect to policies and contracts:

(a) Assure payment of benefits that would have been payable under the policies of the impaired or insolvent insurer, for claims incurred:

(1) with respect to group policies, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to those policies; or

(2) with respect to individual policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under those policies or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to those policies.

(b) Make diligent efforts to provide all known insureds, enrollees, or annuitants for individual policies or group policy or contract owners with respect to group policies 30 days' notice of the termination pursuant to paragraph (a) of the benefits provided.

(c) With respect to individual policies and contracts, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with paragraph (d), if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

(d)(1) In providing the substitute coverage required under paragraph (c), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates subject to prior approval of the commissioner.

(2) Alternative or reissued policies or contracts must be offered without requiring evidence of insurability, and must not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

(3) The association may reinsure any alternative or reissued policy or contract.

(e)(1) Alternative policies or contracts adopted by the association are subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(2) Alternative policies or contracts must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured, but must not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(3) Any alternative policy or contract issued by the association must provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(f) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium must be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the commissioner.

(g) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract ceases on the date the coverage, or on the date the policy or contract is replaced by another similar policy or contract by the policy or contract holder, the insured, the enrollee, or the association and the preexisting condition limitations have been satisfied.

(h) When proceeding under this subdivision with respect to any policy carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 61B.19, subdivision 3, clause (12).

Subd. 4a. **Board discretion.** The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of sections 61B.18 to 61B.32 in an economical and efficient manner.

Subd. 4b. **Benefits provided under a plan.** Where the association has arranged or offered to provide the benefits of sections 61B.18 to 61B.32 to a covered person under a plan or arrangement that fulfills the association's obligations under sections 61B.18 to 61B.32, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

Subd. 4c. **Coverage of policies with indexed interest or similar provisions.** In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under sections 61B.18 to 61B.32, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index, or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) in lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate or (ii) payment of dividends with minimum guarantees or (iii) a different method for calculating interest or changes in value;

(2) there is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(3) the alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Subd. 5. **Obligations terminated.** Nonpayment of all unpaid premiums within 31 days after the date required under the terms of a guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy, contract, or coverage under sections 61B.18 to 61B.32 with respect to the policy, contract, or coverage, except with respect to claims incurred or net cash surrender value that may be due in accordance with sections 61B.18 to 61B.32. The association will not terminate the policy or contract for nonpayment of premium until 31 days after the association sends a written cancellation notice by first class mail to the insured's last known address.

Subd. 6. **Postliquidation premiums.** Premiums due for coverage after entry of any order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due policy or contract owners arising after the entry of the order.

Subd. 7. **Coverage by another state.** The association has no liability under this section for a covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides protection, by statutes or rule, for residents of this state, which protection is substantially similar to that provided by sections 61B.18 to 61B.32, for residents of other states. Recovery provided for under sections 61B.18 to 61B.32 is reduced by the amount of recovery under the coverage provided by another state or jurisdiction. If another state or jurisdiction providing substantially similar coverage as provided by sections 61B.18 to 61B.32 denies coverage, the association shall provide coverage if the policyholder or contract holder is otherwise eligible, and the association is then subrogated to the rights of the person receiving benefits with respect to the other state or jurisdiction. If a person receiving benefits from the association has a claim remaining against another state or jurisdiction, whether or not such state or jurisdiction provides substantially similar protection within the meaning of this section, then such person's remaining claim has priority over any subrogation rights of the association with respect to that other state or jurisdiction.

Subd. 8. **Liens and moratoriums.** (a) In carrying out its duties under subdivision 2 or 3, the association may request that there be imposed policy liens, contract liens, moratoriums on payments, or other similar means. The liens, moratoriums, or similar means may be imposed if the commissioner:

(1) finds: (i) that the amounts that can be assessed under sections 61B.18 to 61B.32 are less than the amounts necessary to assure full and prompt performance of the impaired insurer's contractual obligations; (ii) that economic or financial conditions as they affect member insurers are sufficiently adverse to cause the imposition of policy or contract liens, moratoriums, or similar means to be in the public interest; (iii) that there is a reasonable likelihood that a plan of rehabilitation will be developed or other appropriate arrangements made for the orderly provision for covered contractual obligations of the impaired or insolvent insurer, and that the imposition of policy or contract liens, moratoriums, or similar means is necessary and appropriate to support the development of the plan of rehabilitation or other appropriate arrangements; (iv) that the imposition of policy or contract liens, moratoriums, or similar means is necessary and appropriate to ensure the equitable treatment of all policyholders of impaired or insolvent insurers protected by the guaranty association; (v) that the imposition of policy or contract liens, moratoriums, or similar means is necessary and appropriate to encourage recovery of the maximum possible amount from the remaining assets of the impaired or insolvent insurer's estate; or (vi) that the imposition of policy or contract liens, moratoriums, or similar means is necessary and appropriate in order for the association to participate in any multistate plan of rehabilitation, conservation, or liquidation of the impaired or insolvent insurer, and the commissioner considers the plan to be in the best interests of the impaired or insolvent insurer's policyholders or the association's member insurers;

(2) finds, in the case of a moratorium, that current contractual obligations are being, and will continue to be, promptly paid; and

(3) approves the specific policy liens, contract liens, moratoriums, or similar means to be used.

(b) Before being obligated under subdivision 2 or 3, the association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans. The temporary moratoriums and liens may be imposed if approved by the commissioner.

(c) A moratorium, lien, or other means imposed pursuant to this subdivision may be for: (i) a specific term; or (ii) an indefinite term which shall continue in effect until the commissioner, at the request of the association or, on the commissioner's own motion after notice to the association, finds that the reason or reasons for the moratorium, lien, or other means no longer exists.

Subd. 8a. **Deposits in this state for insolvent or impaired insurer.** A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, pursuant to section 60B.54, shall be promptly paid to the association. The association is entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency. The association shall remit to the domiciliary receiver the amount so paid to the association and not retained pursuant to this subdivision. Any amount retained by the association shall be treated as a distribution of estate assets pursuant to section 60B.46 or similar provision of the state of domicile of the impaired or insolvent insurer.

Subd. 9. **Failure to act.** If the association fails to act within a reasonable period of time as provided in subdivision 2, paragraph (a), clause (2); 3; or 4, the commissioner has the powers and duties of the association with respect to impaired or insolvent insurers including, but not limited to, the power to make assessments.

Subd. 10. **Assistance to commissioner.** The association may give assistance and advice to the commissioner, upon request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

Subd. 11. **Standing in court.** The association has standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under sections 61B.18 to 61B.32 or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise. This standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association may appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise, provided, however, in the case of any such appearance or intervention, the association shall not submit for adjudication its obligations to provide coverage under the Minnesota Life and Health Insurance Guaranty Association Act without the prior approval of the commissioner.

Subd. 12. **Assignments; subrogation rights.** (a) A person receiving benefits under sections 61B.18 to 61B.32 shall be considered to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of sections 61B.18 to 61B.32, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of those rights and causes of action by an enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of rights or benefits conferred by sections 61B.18 to 61B.32 upon that person. The assignment and subrogation rights of the association include any rights that a person may have as a beneficiary of a plan covered under the Employee Retirement Income Security Act of 1974, United States Code, title 29, section 1003, as amended.

(b) The subrogation rights of the association under this subdivision against the assets of the impaired or insolvent insurer have the same priority as those of a person entitled to receive benefits under sections 61B.18 to 61B.32.

(c) In addition to paragraphs (a) and (b), the association has all common law rights of subrogation and other equitable or legal remedies that would have been available to the impaired or insolvent insurer or person receiving benefits under sections 61B.18 to 61B.32 including without limitation, in the case of a structured settlement annuity, any rights of the owner, enrollee, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to sections 61B.18 to 61B.32, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment thereof, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code of 1986, as amended.

(d) If the preceding provisions of this subdivision are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portion thereof covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subdivision, the person shall pay to the association the portion of the recovery attributable to the policies or contracts or portion thereof covered by the association.

Subd. 13. **Permissive powers.** The association may:

(1) enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 61B.18 to 61B.32;

(2) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 61B.26 to settle claims or potential claims against it;

(3) borrow money to effect the purposes of sections 61B.18 to 61B.32 and any notes or other evidence of indebtedness of the association not in default are legal investments for domestic member insurers and may be carried as admitted assets;

(4) employ or retain persons as are necessary or appropriate to handle the financial transactions of the association, and to perform other functions as the association considers necessary or proper under sections 61B.18 to 61B.32;

(5) enter into arbitration or take legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(6) exercise, for the purposes of sections 61B.18 to 61B.32 and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer, or health maintenance organization, but in no case may the association issue policies or contracts other than those issued to perform its obligations under sections 61B.18 to 61B.32;

(7) join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association;

(8) negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association;

(9) participate in the organization of and/or own stock in an entity which exists or was formed for the purpose of assuming liability for contracts or policies issued by impaired or insolvent insurers;

(10) request information from a person seeking coverage from the association in order to aid the association in determining its obligations under sections 61B.18 to 61B.32 with respect to the person, and the person shall promptly comply with the request;

(11) in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under sections 61B.18 to 61B.32; and

(12) take other necessary or appropriate action to discharge its duties and obligations under sections 61B.18 to 61B.32, or to exercise its powers under sections 61B.18 to 61B.32.

Subd. 14. **Association election to succeed to rights of insolvent or impaired insurer under indemnity reinsurance contracts.** (a) At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer the coverage date, the association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to policies, contracts, or annuities covered in whole or in part by the association, under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator, or liquidator, and to the affected reinsurers. If the association makes an election, clauses (1) through (4) apply with respect to the agreements selected by the association:

(1) the association is responsible for all unpaid premiums due under the agreements for periods both before and after the coverage date, and is responsible for the performance of all other obligations to be performed after the coverage date, in each case that relates to contracts covered in whole or in part by the association and the association may charge policies, contracts, or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association;

(2) the association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to policies, contracts, or annuities covered by the association in whole or in part, provided that, upon receipt of any such amounts, the association is obliged to pay to the beneficiary under the policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to the excess of:

(i) the amount received by the association, over

(ii) the benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event;

(3) within 30 days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer or its receiver, rehabilitator, or liquidator or the indemnity reinsurer during the period between the coverage date and the date of the association's election and (i) either the association or indemnity reinsurer shall pay the net balance due the other within five days of the completion of the aforementioned calculation and (ii) if the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to paragraph (a), the receiver, rehabilitator, or liquidator shall remit the same to the association as promptly as practicable; and

(4) if the association, within 60 days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association in whole or in part, the reinsurer shall not be entitled to terminate the reinsurance agreements insofar as the agreements relate to contracts covered by the association in whole or in part and shall not be entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association.

(b) In the event the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under paragraph (a) effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in paragraph (a) provided that:

(1) the indemnity reinsurance agreements shall automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

(2) the obligations described in the proviso to paragraph (a), clause (2), shall no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third-party insurer; and

(3) paragraph (b) does not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in paragraph (a).

(c) The provisions of this subdivision shall supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date subject to applicable setoff provisions.

(d) Except as otherwise expressly provided in this subdivision, nothing in this subdivision alters or modifies the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. Nothing in this subdivision abrogates or limits any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. Nothing in this subdivision gives a policy owner, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

Subd. 15. **Venue; appeal bond.** Except as otherwise provided in section 61B.24, subdivision 10, or 61B.26, paragraph (c), venue in a suit against the association arising under sections 61B.18 to 61B.32 shall be in Ramsey County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under sections 61B.18 to 61B.32.

History: *1993 c 319 s 8; 2001 c 142 s 15-25; 2002 c 379 art 1 s 27; 2020 c 80 art 2 s 11-17*

61B.24 ASSESSMENTS.

Subdivision 1. **Purpose.** For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account or subaccount, at the times and for the amounts as the board finds necessary. Assessments are due not less than 30 days after prior written notice to the member insurers and accrue interest on and after the due date at the then applicable rate determined under section 549.09, subdivision 1, paragraph (c).

Subd. 2. **Classes of assessments.** There are two classes of assessments, as follows:

(1) class A assessments must be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of section 61B.27. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer; and

(2) class B assessments must be made to the extent necessary to carry out the powers and duties of the association under section 61B.23 with regard to an impaired or an insolvent insurer.

Subd. 3. **Formula for determination.** (a) The amount of a class A assessment shall be determined by the board and may be made on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future class B assessments.

(b) The amount of any class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard considered by the board in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for 50 percent of the assessment to be allocated to health insurance member insurers and 50 percent to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each subaccount or account must be in the proportion that the average annual premiums received on business in this state by each assessed member insurer on policies or contracts covered by each subaccount or account for the three most recent calendar years for which information is available preceding the calendar year in which the member insurer became impaired or insolvent, as the case may be, bears to the average annual premiums received on business in this state by all assessed member insurers on policies or contracts covered by that subaccount or account for those same calendar years. If the impaired insurer becomes insolvent, the date of insolvency must be used to determine the assessment. Premiums for purposes of calculating average annual premium for calendar years prior to 1993 shall be determined in accordance with Minnesota Statutes 1992, sections 61B.01 to 61B.16.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer must not be made until necessary to implement the purposes of sections 61B.18 to 61B.32. Classification of assessments under subdivision 2 and computation of assessments under this subdivision must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

Subd. 4. **Abatement or deferment.** The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments as provided in this section. Once the conditions which caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

Subd. 5. **Maximum assessment.** (a) The total of all assessments upon a member insurer for each subaccount of the life and annuity account and for the health account shall not in any one calendar year exceed two percent of that member insurer's average annual premiums as calculated in subdivision 3, paragraph (d), on policies or contracts covered by that account or subaccount. If two or more assessments

are made with respect to member insurers that become impaired or insolvent in different calendar years, average annual premiums for purposes of the assessment percentage limitation are based upon the higher of the three-year averages calculated under subdivision 3, paragraph (d). If an impaired insurer becomes insolvent, the date of impairment must be used to determine the assessment. If the maximum assessment for any subaccount of the life and annuity account in any one calendar year will not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision 3, the board of directors shall assess based on the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum of two percent stated above for each subaccount.

(b) If the maximum assessment for an account, together with the other assets of the association in that account, does not provide in any one calendar year in that account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon as permitted by sections 61B.18 to 61B.32.

(c) The board may adopt general principles in the plan of operation for allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(d) If assessments under this section are inadequate to pay all obligations of the impaired insurer that are or become due and owing, then the association shall prepare a plan approved by the commissioner for prioritization of payments. If the association adopts general principles in the plan of operations, the association shall use the general principles in preparing the plan required under this paragraph. No formerly impaired or insolvent insurer may be reinstated until all payments of or on account of the insurer's or health maintenance organization's contractual obligations by the guaranty association, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty association or a plan of repayment by the insurer or health maintenance organization shall have been approved by the commissioner.

Subd. 6. **Refund.** The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account or subaccount, the amount by which the assets of the account or subaccount exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account or subaccount, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account or subaccount to provide funds for the continuing expenses of the association and for future losses.

Subd. 7. **Premium rates and dividends.** A member insurer may, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of sections 61B.18 to 61B.32, consider the amount reasonably necessary to meet its assessment obligations under sections 61B.18 to 61B.32.

Subd. 8. **Certificate of contribution.** The association shall issue to each member insurer paying an assessment under sections 61B.18 to 61B.32, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in the form and for the amount, if any, and period of time as the commissioner may approve.

Subd. 9. **Survival of obligation.** In the event a member insurer engages in any reorganization, including any merger, consolidation, restructuring, incorporation, or reincorporation, the member's obligations under

this chapter shall survive the reorganization with respect to assessments for impairments or insolvencies occurring before the date of the reorganization.

Subd. 10. **Procedure for protests regarding assessments.** (a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment is available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within 60 days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within 30 days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer the protest to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

Subd. 11. **Member insurers' duty to provide information to association.** The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

History: *1993 c 319 s 9; 2001 c 142 s 26-29; 2020 c 80 art 2 s 18-23*

61B.25 PLAN OF OPERATION.

Subdivision 1. **Adoption and amendment.** The purpose of the plan of operation is to assure the fair, reasonable, and equitable administration of the association under sections 61B.18 to 61B.32. Amendments to the plan of operation must be submitted to the commissioner and become effective upon the commissioner's written approval or 30 days after submission if the commissioner has not disapproved. If the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to implement sections 61B.18 to 61B.32. The rules shall continue in force until modified by the commissioner or superseded by amendments submitted by the association and approved by the commissioner.

Subd. 2. **Compliance.** All member insurers shall comply with the plan of operation.

Subd. 3. **Contents.** The plan of operation must, in addition to requirements specified in sections 61B.18 to 61B.32:

(1) establish procedures for handling the assets of the association;

(2) establish the amount and method of reimbursing members of the board of directors under section 61B.22;

(3) establish regular places and times for meetings including telephone conference calls of the board of directors or of the executive committee;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish procedures for selecting the board of directors;

(6) establish any additional procedures for assessments under section 61B.24; and

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Subd. 4. **Delegation of powers and duties.** The plan of operation may provide that any or all powers and duties of the association, except those under sections 61B.23, subdivision 13, clause (3), and 61B.24, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subdivision shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by sections 61B.18 to 61B.32.

History: *1993 c 319 s 10*

61B.26 DUTIES AND POWERS OF COMMISSIONER.

(a) In addition to other duties and powers in sections 61B.18 to 61B.32, the commissioner shall:

(1) notify the board of directors of the existence of an impaired or insolvent insurer within three days after a determination of impairment or insolvency is made or the commissioner receives notice of impairment or insolvency;

(2) upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(3) when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the impaired insurer to promptly comply with the commissioner's demand shall not excuse the association from the performance of its powers and duties under sections 61B.18 to 61B.32; and

(4) in a liquidation, conservation, or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator, conservator, or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. A forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(c) A final action of the board of directors or the association may be appealed to the commissioner if the appeal is taken within 60 days of the aggrieved party's receipt of notice of the final action being appealed.

Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction, in the manner provided by chapter 14. A determination or decision by the commissioner under sections 61B.18 to 61B.32 is not subject to the contested case or rulemaking provisions of chapter 14.

(d) The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of sections 61B.18 to 61B.32.

(e) For the purposes of sections 61B.18 to 61B.32, the commissioner may delegate any of the powers conferred by law.

(f) Nonperformance of any of the acts specified in this section or failure to meet the specific time limits does not affect the association, its members, or any other person as to the person's duties and obligations.

History: *1993 c 319 s 11; 2001 c 142 s 30; 2020 c 80 art 2 s 24*

61B.27 PREVENTION OF INSOLVENCIES.

(a) To aid in the detection and prevention of member insurer insolvencies or impairments the commissioner shall notify the commissioners of insurance of all the other states, territories of the United States, and the District of Columbia when the commissioner takes one of the following actions against a member insurer:

(i) revocation of license; or

(ii) suspension of license.

The notice must be mailed to all commissioners within 30 days following the action.

(b) If the commissioner deems it appropriate, the commissioner may:

(1) Report to the board of directors when the commissioner has taken any of the actions specified in paragraph (a) or has received a report from another commissioner indicating that an action specified in paragraph (a) has been taken in another state. The report to the board of directors must contain all significant details of the action taken or the report received from another commissioner.

(2) Report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member company that the company may be an impaired or insolvent insurer.

(3) Furnish to the board of directors the National Association of Insurance Commissioners insurance regulatory information system ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information in carrying out its duties and responsibilities under this section. The report and the information contained in it must be kept confidential by the board of directors until it has been made public by the commissioner or other lawful authority. Nothing in this provision supersedes other requirements of law.

(4) Notify the board if the commissioner makes a formal order requiring the member insurer to restrict its premium writing, obtain additional contributions to surplus, withdraw from this state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders, contract holders, certificate holders, or creditors.

(c) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of

member insurers and of insurers or health maintenance organizations seeking admission to transact business in this state.

(d) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon matters germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of an insurer or health maintenance organization seeking to do business in this state. Those reports and recommendations shall not be considered public documents.

(e) The board of directors, upon majority vote, may notify the commissioner of information indicating that a member insurer may be an impaired or insolvent insurer.

(f) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

(g) The board of directors may, at the conclusion of an insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing the information it may have in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer or health maintenance organization, and may adopt by reference any report prepared by those other associations.

(h) Nonperformance by the commissioner of any of the acts specified in this section or failure to meet the specified time limits does not affect the association, its members, or any other person as to the person's duties and obligations.

Nothing in this section supersedes other requirements of law.

History: *1993 c 319 s 12; 2001 c 142 s 31; 2020 c 80 art 2 s 25*

61B.28 MISCELLANEOUS PROVISIONS.

Subdivision 1. **Records.** Records must be kept of all negotiations and meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 61B.23. Records of the association with respect to an impaired or insolvent insurer shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subdivision limits the duty of the association to report its activities under section 61B.27.

Subd. 2. **Reports.** (a) A report, recommendation, or notification by the association, its board of directors, or officers to the commissioner concerning a member insurer, together with statements or documents furnished to the commissioner with, or subsequent to, a report, recommendation, or notification, is confidential and a privileged communication. Reports, recommendations, notifications, statements, and documents furnished to the commissioner are not admissible in whole or in part for any purpose in an action or proceeding against:

(1) the association or its member insurers, officers, employees, or representatives submitting or providing the report, recommendation, notification, statement, or document; or

(2) a person, firm, or entity who in good faith furnishes to the association the information or document upon which the association has relied in making its report, recommendation, or notification to the commissioner.

(b) Notwithstanding the provisions of sections 13.711, 13.715, and 13.719, the commissioner may release to the association's board of directors any or all nonpublic data collected and maintained by the commissioner on a member insurer or a potential member insurer. Information furnished to the board of directors is private.

Subd. 3. **Association as creditor.** For the purpose of carrying out its obligations under sections 61B.18 to 61B.32, the association is considered to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies, reduced by amounts which the association recovers from the assets of the impaired or insolvent insurer as subrogee under section 61B.23, subdivision 12. Recoveries by the association as subrogee under section 61B.23, subdivision 12, from assets other than from assets of the impaired or insolvent insurer shall not reduce or act as an offset to the association's claim as creditor of the impaired or insolvent insurer. Assets of the impaired or insolvent insurer attributable to covered policies or contracts must be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer as required by sections 61B.18 to 61B.32. Assets attributable to covered policies or contracts, as used in this subdivision, are that proportion of the assets which the reserves that should have been established for those policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

Subd. 3a. **Association access to insolvent insurer's assets.** As a creditor of the impaired or insolvent insurer as established in subdivision 3 of this section and consistent with section 60B.46, the association and other similar associations is entitled to receive a disbursement of assets out of the marshalled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under sections 61B.18 to 61B.32. If the liquidator has not, within 120 days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshalled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

Subd. 4. **Prohibited sales practice.** No person, including a member insurer, agent, or affiliate of a member insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, an advertisement, announcement, or statement, written or oral, which uses the existence of the Minnesota Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by sections 61B.18 to 61B.32. The notice required by subdivision 8 is not a violation of this subdivision nor is it a violation of this subdivision to explain verbally to an applicant or potential applicant the coverage provided by the Minnesota Life and Health Insurance Guaranty Association at any time during the application process or thereafter. This subdivision does not apply to the Minnesota Life and Health Insurance Guaranty Association or an entity that does not sell or solicit insurance or coverage by a health maintenance organization.

Subd. 5. **Distribution to stockholders.** No distribution to stockholders of an impaired domiciliary insurer shall be made until the total amount of assessments levied by the association with respect to the insurer have been fully recovered by the association.

Subd. 6. **Reinstatement.** No member insurer may be reinstated to do business in this state until all payments of or on account of the impaired insurer's contractual obligations by the guaranty association, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty association or a plan of repayment by the impaired insurer shall have been approved by the association.

Subd. 7. **Notice concerning limitations and exclusions.** (a) No person, including a member insurer, agent, or affiliate of a member insurer or agent, shall offer for sale in this state a covered life insurance, annuity, or health insurance policy or contract without delivering, either at the time of application for that policy or contract or at the time of delivery of the policy or contract, a notice in the form specified in subdivision 8, or in a form approved by the commissioner under paragraph (b), relating to coverage provided by the Minnesota Life and Health Insurance Guaranty Association. The notice may be part of the application. A copy of the notice must be given to the applicant or the policy owner, contract owner, certificate holder, or enrollee. The person offering the policy or contract shall document the fact that the notice was given at the time of application or the fact that the notice was delivered at the time the policy or contract was delivered. This does not require that the receipt of the notice be acknowledged by the applicant.

(b) The association may prepare, and file with the commissioner for approval, a form of notice as an alternative to the form of notice specified in subdivision 8 describing the general purposes and limitations of this chapter. The form of notice shall:

(1) state the name, address, and telephone number of the Minnesota Life and Health Insurance Guaranty Association;

(2) prominently warn the policy owner, contract owner, certificate holder, or enrollee that the Minnesota Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(3) state that the member insurer and its agents are prohibited by law from using the existence of the Minnesota Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

(4) emphasize that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the Minnesota Life and Health Insurance Guaranty Association when selecting an insurer or health maintenance organization;

(5) provide other information as directed by the commissioner. The commissioner may approve any form of notice proposed by the association and, as to the approved form of notice, the association may notify all member insurers by mail or other electronic means that the form of notice is available as an alternative to the notice specified in subdivision 8.

(c) A policy or contract not covered by the Minnesota Life and Health Insurance Guaranty Association or the Minnesota Insurance Guaranty Association must contain the following notice in ten-point type, stamped in red ink or contrasting type on the policy or contract and the application:

"THIS POLICY OR CONTRACT IS NOT PROTECTED BY THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE MINNESOTA INSURANCE GUARANTY ASSOCIATION. IN THE CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED. ONLY THE ASSETS OF THIS INSURER OR HEALTH MAINTENANCE ORGANIZATION WILL BE AVAILABLE TO PAY YOUR CLAIM."

This section does not apply to fraternal benefit societies regulated under chapter 64B.

Subd. 8. **Form.** The form of notice referred to in subdivision 7, paragraph (a), is as follows:

"....

....

.....

(insert name, current address, and

telephone number of member insurer)

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN

INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH

INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance organization coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association

(insert current

address and telephone number)

The maximum amount the guaranty association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty

association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY, CONTRACT, OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE."

Additional language may be added to the notice if approved by the commissioner prior to its use in the form. This section does not apply to fraternal benefit societies regulated under chapter 64B.

Subd. 9. **Combination fixed-variable policy.** The notice required in subdivision 8 must clearly describe what portions of a combination fixed-variable policy are not covered by the Minnesota Life and Health Insurance Guaranty Association. The notice requirements specified in subdivision 7, paragraph (c), do not apply to a combination fixed-variable policy.

Subd. 10. **Effect of notices.** The distribution, delivery, contents, or interpretation of the notices described in subdivision 7, 8, or 9 shall not mean that either the policy or contract, or the owner or holder thereof, would be covered in the event of the impairment or insolvency of a member insurer if coverage is not otherwise provided by sections 61B.18 to 61B.32. Failure to receive the notice does not give the policyholder, contract holder, certificate holder, insured, owner, beneficiaries, assignees, or payees any greater rights than those provided by sections 61B.18 to 61B.32.

History: *1993 c 319 s 13; 1995 c 258 s 19,20; 1996 c 446 art 1 s 21; 1999 c 227 s 22; 2001 c 142 s 32-34; 2009 c 37 art 3 s 16,17; 2010 c 275 art 1 s 12; 2020 c 80 art 2 s 26-31*

61B.29 EXAMINATION; ANNUAL REPORT.

The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner before May 1 each year, a financial report in a form approved by the commissioner and a report of its activities during the association's preceding fiscal year. Upon request of a member insurer, the association must provide the member insurer with a copy of the report.

History: *1993 c 319 s 14; 2001 c 142 s 35*

61B.30 TAX EXEMPTIONS.

Subdivision 1. **State fees and taxes.** The association is exempt from payment of all taxes imposed under chapter 297I and all fees and all other taxes levied by this state or its subdivisions, except taxes levied on real property.

Subd. 2. **Federal and foreign state taxes.** The association may seek exemption from payment of all fees and taxes levied by the federal or any other state government or its subdivision.

History: *1993 c 319 s 15; 2000 c 394 art 2 s 12*

61B.31 INDEMNIFICATION.

The association has authority to indemnify certain persons against certain expenses and liabilities as provided in section 302A.521, including the power to purchase and maintain insurance on behalf of these persons as provided by section 302A.521, subdivision 7. In applying section 302A.521 for this purpose, the term "member insurers" shall be substituted for the terms "shareholders" and "stockholders" and the term "association" shall be substituted for the term "corporation."

History: *1993 c 319 s 16; 2005 c 69 art 3 s 13*

61B.32 STAY OF PROCEEDINGS; REOPENING DEFAULT JUDGMENTS.

All proceedings in which the insolvent insurer is a party in a court in this state must be stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on matters germane to its powers or duties. As to judgment under a decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and may defend against the suit on the merits.

History: *1993 c 319 s 17*

61B.33 RIGHTS AND OBLIGATIONS OF ASSOCIATION.

Notwithstanding any other provision of law, the provisions of the Minnesota Life and Health Insurance Guaranty Association Act in effect on the date the association first becomes obligated for the policies or contracts of an insolvent or impaired member insurer govern the association's rights or obligations to the policy owners, contract owners, or enrollees of the insolvent or impaired member insurer.

History: *2020 c 80 art 2 s 32*