CHAPTER 60A

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60A.01 SCOPE.

This chapter includes the provisions relating to administration in general and the provisions applicable to insurance in general.

History: *1967 c 395 art 1 s 1*

60A.02 DEFINITIONS.

Subdivision 1. **Terms.** Unless the language or context clearly indicates that a different meaning is intended, the following terms shall, for the purposes of chapters 60A to 72A, 69, 70A and 299F, have the meanings ascribed to them.

Subd. 1a. **Association or associations.** (a) "Association" or "associations" means an organized body of people who have some interest in common and that has at the onset a minimum of 100 persons; is organized and maintained in good faith for purposes other than that of obtaining insurance; and has a constitution and bylaws which provide that: (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members; (2) except for credit unions, the association or associations collect dues or solicit contributions from members; (3) the members have voting privileges and representation on the governing board and committees, which provide the members with control of the association including the purchase and administration of insurance products offered to members; and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold an insurance policy if the policy is available as an association benefit.

(b) An association may apply to the commissioner for a waiver of the 30-day waiting period to that association. The commissioner may grant the waiver upon a finding of at least three of the following: (1) the association is in full compliance with this subdivision; (2) sanctions have not been imposed against the association as a result of significant disciplinary action by the commissioner; (3) at least 80 percent of the association's income comes from dues, contributions, or sources other than income from the sale of insurance; or (4) the association has been organized and maintained for at least ten years.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce of the state of Minnesota and, in the commissioner's absence or disability, a deputy or other person duly designated to act in the commissioner's place.

Subd. 2a. **Continued.** An insurance policy that is issued for a term in excess of one year or that has no specified term or that is designated as being continuous is "continued" each year on the anniversary date of the issuance of the policy.

Subd. 2b. **Filed.** In cases where a law requires documents to be filed with the commissioner, the documents will be considered filed when they are received by the Department of Commerce.

Subd. 3. **Insurance.** (a) "Insurance" is any agreement whereby one party, for a consideration, undertakes to indemnify another to a specified amount against loss or damage from specified causes, or to do some act of value to the assured in case of such loss or damage. A program of self-insurance, self-insurance revolving fund or pool established under section 471.981 is not insurance for purposes of this subdivision.

(b) [Expired]

Subd. 4. **Company or insurance company.** "Company" or "insurance company" includes every insurer, corporation, business trust, or association engaged in insurance as principal, but for purposes of this

subdivision does not include a political subdivision providing self-insurance or establishing a pool under section 471.981, subdivision 3.

Subd. 4a. **Mutual property and casualty insurance company.** "Mutual property and casualty insurance company" includes a property and casualty insurance company that was converted to a stock company after December 31, 1987, and before January 1, 1994, if the company was controlled on the date of conversion by a mutual life insurance company and so long as the company continues to be controlled by a mutual life insurance company.

Subd. 5. **Domestic.** "Domestic" shall designate those companies incorporated or organized in this state.

Subd. 6. **Foreign.** "Foreign," when used without limitations, shall designate those companies incorporated or organized in any other state or country.

Subd. 7. **Insurance agent or insurance agency.** An "insurance agent" or "insurance agency" is an insurance producer licensed under sections 60K.30 to 60K.56 acting under express authority from, and an appointment by, an insurer and on its behalf to solicit insurance, or to appoint other insurance producers to solicit insurance, or to write and countersign policies of insurance, or to collect premiums therefor within this state, or to exercise any or all these powers when so authorized by the insurer. The term "person" includes a natural person, a partnership, a corporation, or other entity, including an insurance agency.

Subd. 8. [Repealed, 1981 c 307 s 22]

Subd. 9. **Net assets.** "Net assets" means that portion of the excess of the entire assets of an insurance company over its entire liabilities, exclusive of capital, and inclusive of policy liability, available for the payment of its obligations, including capital stock in this state and including as assets deferred premiums on policies written within three months and actually in force; and, in the case of a mutual marine or fire and marine company, its subscription funds and premium notes not more than 30 days past due and uncollected. In the case of a mutual fire insurance company, there shall be included as assets premium notes absolutely payable within six months from date and given for policies actually in force, when such notes are not more than 30 days overdue. Unpaid guaranty fund subscriptions shall not be included as assets, and guaranty fund certificates upon which there is no liability of the company until all of its other obligations and liabilities are paid shall not be included as a liability.

Subd. 10. **Earned premiums.** "Earned premiums" includes gross premiums charged on all policies written, including all determined excess and additional premiums, less return premiums, other than premiums returned to policyholders as dividends, and less reinsurance premiums and premiums on policies canceled, and less unearned premiums on policies in force. Any participating company which has charged in its premiums a loading solely for dividends shall not be required to include such loading in its earned premiums; provided, a statement of the amount of such loading has been filed and approved by the commissioner.

Subd. 11. **Unearned premiums, insurance reserve, net value policies, and premium reserve.** "Unearned premiums," "insurance reserve," "net value policies," and "premium reserve" severally refer to the liability of an insurance company upon its insurance contracts other than accrued claims computed by rules on valuation herein established.

Subd. 12. **Profits.** "Profits" of a mutual insurance company means that portion of its net earnings not required for payment of losses and expenses, nor set apart for any lawful purposes.

Subd. 13. **Loss payments and loss expense payments.** The terms "loss payments" and "loss expense payments" include all payments to claimants, including payments for medical and surgical attendance, legal expense, salaries and expenses of investigators, adjusters, and field representatives, rents, stationery, telegraph

and telephone charges, postage, salaries and expenses of office employees, home office expenses, and all other payments made on account of claims, whether such payments shall be allocated to specific claims or unallocated.

Subd. 14. **Compensation.** The term "compensation" relates to all insurance effected by virtue of statutes providing compensation to employees for personal injuries irrespective of fault of the employer.

Subd. 15. **Liability.** The term "liability" relates to all insurance, except compensation insurance, against loss or damage from accident to or injuries suffered by an employee or other person and for which the insured is liable.

Subd. 16. **Department of Commerce.** "Department of Commerce" of the state of Minnesota also means Department of Commerce or commissioner of commerce.

Subd. 17. **Leasehold estate.** The term "leasehold estate" means an estate in land which includes the ground lease covering the land and any improvements thereon.

Subd. 18. **State.** "State" means any state of the United States of America, the District of Columbia, the Commonwealth of Puerto Rico and any other possessions of the United States.

Subd. 19. **Alien.** "Alien" means an insurer domiciled outside of the United States, but conducting business within the United States.

Subd. 20. **Assume.** "Assume" means to accept all or part of a ceding company's insurance or reinsurance on a risk or exposure.

Subd. 21. **Cede.** "Cede" means to pass on to another insurer all or part of the insurance written by an insurer for the purpose of reducing the possible liability of the insurer.

Subd. 22. **Cession.** "Cession" means the unit of insurance passed to a reinsurer by an insurer which issued a policy to the insured.

Subd. 23. **Facultative reinsurance.** "Facultative reinsurance" means the reinsurance of part or all of the insurance provided by a single policy, with separate negotiation for each cession.

Subd. 24. **Reinsurer.** "Reinsurer" means an insurer which assumes the liability of another insurer through reinsurance.

Subd. 25. **Retrocession.** "Retrocession" means a transaction in which a reinsurer cedes to another reinsurer all or part of the reinsurance that the reinsurer had previously assumed.

Subd. 26. **United States branch.** "United States branch" means the business unit through which business is transacted within the United States by an alien insurer.

Subd. 27. **Admitted assets.** "Admitted assets" means the assets as shown by the company's annual statement on December 31 valued according to valuation regulations prescribed by the National Association of Insurance Commissioners and procedures adopted by the National Association of Insurance Commissioners' financial condition Ex 4 subcommittee if not addressed in another section, unless the commissioner requires or finds another method of valuation reasonable under the circumstances.

Subd. 28. **Group insurance.** "Group insurance" means that form of insurance coverage sponsored by:

(1) an employer covering not less than two employees and which may include the employees' dependents, consisting of spouses, children, and actual dependents residing in the household, written under a master

policy issued to any employer, or group of employers who have joined into an arrangement for the purposes of providing the employees insurance for their individual benefit. Employees' dependents, consisting of spouses, children, and actual dependents residing in the same household, are not employees for purposes of this definition except for a spouse employed on a regular full-time basis by the same employer. This clause does not apply to chapter 62L;

(2) an association to provide insurance to its members; or

(3) a creditor to provide life insurance to insure its debtors in connection with real estate mortgage loans, in an amount not to exceed the actual or scheduled amount of their indebtedness.

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

History: *1967 c 395 art 1 s 2; 1969 c 494 s 1,2; 1971 c 24 s 9; 1980 c 529 s 1,2; 1981 c 307 s 1; 1983 c 289 s 114 subd 1; 1983 c 328 s 1; 1984 c 655 art 1 s 92; 1Sp1985 c 10 s 49; 1986 c 444; 1989 c 260 s 1; 1991 c 325 art 1 s 1-9; art 10 s 1; 1992 c 564 art 1 s 13; art 3 s 1; 1994 c 485 s 4; 1994 c 587 art 1 s 1; 1994 c 625 art 8 s 1; 1995 c 234 art 7 s 1; 1999 c 177 s 1,2; 2001 c 117 art 2 s 3; 2024 c 101 art 3 s 2*

60A.03 COMMISSIONER OF COMMERCE.

Subdivision 1. **Commissioner; appointment.** The commissioner of commerce shall be appointed by the governor under the provisions of section 15.06. All of the commissioner's time shall be devoted to the duties of the office.

Subd. 2. **Powers of commissioner.** The commissioner shall have and exercise the power to enforce all the laws of this state relating to insurance, and shall enforce all the provisions of the laws of this state relating to insurance in the manner provided by the laws defining the powers and duties of the commissioner of commerce, or, in the absence of any law prescribing the procedure, by any reasonable procedure the commissioner prescribes.

Subd. 3. **Appointment of staff and officials.** (1) **Official staff.** The commissioner may appoint a deputy or assistant commissioner of commerce to assist in the commissioner's duties, an actuary, a chief examiner, a statistician, and such assistants to these employees and such stenographic and clerical help as may be required for the proper conduct of the Department of Commerce.

(2) **Duties of departmental officials.** In the absence or disability of the commissioner, the commissioner's duties shall be performed by the deputy or assistant commissioner of commerce. The actuary of the department shall, under the direction of the commissioner, make such valuation of life insurance policies as shall be necessary, from time to time, to the proper supervision of life insurance companies transacting business in this state, and shall perform such other actuarial duties, including the visitation and examination of insurance companies, as the commissioner may prescribe. The chief and assistant examiners shall, under the direction of the commissioner, devote their principal time to necessary or required examinations of insurance companies, and perform such other duties as the commissioner may prescribe. Other salaried employees of the Department of Commerce shall be under the direction of the commissioner and perform such duties, in connection with the Department of Commerce, as the commissioner may prescribe.

(3) **Consulting actuary, appointment and compensation.** The commissioner may, when the commissioner shall deem it necessary, appoint any experienced and competent professional insurance actuary to personally make or conduct, or assist in making or conducting, an examination of any insurance company admitted, or applying for admission, to do business in this state, on condition that the commissioner shall

have previously filed with the secretary of state a written declaration designating such person, by name and address, as a consulting actuary of the Department of Commerce. In this case, the commissioner shall fix a reasonable compensation for the actuary on a per diem basis for the actual time employed in making or conducting, or assisting to make or conduct, the examination, which compensation, together with the amount of the necessary expenses actually incurred by the actuary, including expenses of any necessary appraisal or clerical assistance, shall be charged to the company and paid by it to the actuary.

(4) **Appraiser, appointment and compensation.** The commissioner, when deeming it necessary, may appoint any qualified person to make an appraisal of any or all of the assets of any such company. Such person shall be paid such reasonable fees for the appraisal as may be approved by the commissioner and shall also be paid necessary expenses actually incurred in connection with the services. Such compensation and expenses shall be paid by the company.

Subd. 4. [Repealed, 1969 c 7 s 2]

Subd. 5. **Examination fees and expenses.** When any visitation, examination, or appraisal is made by order of the commissioner, the company being examined, visited, or appraised, including, but not limited to, fraternals, township mutuals, reciprocal exchanges, nonprofit service plan corporations, health maintenance organizations, vendors of risk management services licensed under section 60A.23, or self-insurance plans or pools established under section 176.181 or 471.982, shall pay to the Department of Commerce the necessary expenses of the persons engaged in the examination, visit, appraisal, or desk audits of annual statements and records performed by the department other than on the company premises plus the per diem salary fees of the employees of the Department of Commerce who are conducting or participating in the examination, visitation, appraisal, or desk audit. The per diem salary fees may be based upon the approved examination fee schedules of the National Association of Insurance Commissioners or otherwise determined by the commissioner. All of these fees and expenses must be paid into the Department of Commerce revolving fund.

Subd. 6. **Examination revolving fund.** (1) **Revolving fund created.** There is hereby created the Department of Commerce examination revolving fund for the purpose of carrying on the examination of foreign and domestic insurance companies.

(2) **Money in revolving fund.** Such fund shall consist of the $7,500 appropriated therefor and the money transferred to it as herein provided, which are reappropriated to the commissioner of commerce for the purpose of this subdivision.

(3) **Fund to be kept in state treasury.** Such fund shall be kept in the state treasury and shall be paid out in the manner prescribed by law for money therein.

(4) **Purposes for which fund may be expended.** Such fund shall be used for the payment of per diem salaries and expenses of special examiners and appraisers, and the expenses of the commissioner of commerce, deputy commissioner of commerce, chief examiner, actuary other than a consulting actuary appointed under subdivision 3, clause (3) hereof, regular salaried examiners and other employees of the Department of Commerce when participating in examinations. Expenses include meals, lodging, laundry, transportation, and mileage. The salary of regular employees of the Division of Insurance shall not be paid out of this fund.

(5) **Collections to be deposited in fund.** All money collected by the Division of Insurance from insurance companies for fees and expenses of examinations, shall be deposited in the insurance division examination revolving fund.

(6) **Payments from such fund.** Upon authorization by the commissioner of commerce, the money due each examiner or employee engaged in an examination shall be paid from the insurance division examination revolving fund in the manner prescribed by law.

(7) **Excess over $25,000 canceled into general fund.** The balance in such fund on June 30 of each year in excess of $25,000 shall be forthwith canceled into the general fund.

Subd. 7. [Repealed, 1969 c 707 s 1; 1969 c 1129 art 4 s 11]

Subd. 8. **Computation of net value; life insurance.** (1) **Domestic insurers.** The commissioner shall compute, yearly, the net value of all outstanding policies in every company authorized to insure lives in this state, calculated upon the basis stated in section 61A.25.

(2) **Foreign insurers.** The commissioner may accept the valuation made by the insurance commissioner of the state under whose authority a life company was organized, when that valuation has been made on sound and recognized principles and on the legal basis provided in section 61A.25, or its equivalent, when furnished with a certificate of that commissioner setting forth that value on the last day of the preceding year. Every such life company which fails to promptly furnish this certificate shall, on demand, furnish the commissioner detailed lists of all its policies and securities, and shall be liable for all charges and expenses resulting therefrom.

Subd. 9. **Confidentiality of information.** The commissioner may not be required to divulge any information obtained in the course of the supervision of insurance companies, or the examination of insurance companies, including examination related correspondence and work papers, until the examination report is finally accepted and issued by the commissioner, and then only in the form of the final public report of examinations. Nothing contained in this subdivision prevents or shall be construed as prohibiting the commissioner from disclosing the content of this information to the insurance department of another state, the National Association of Insurance Commissioners, the National Association of Securities Dealers, or any national securities association registered under the Securities Exchange Act of 1934, if the recipient of the information agrees in writing to hold it as nonpublic data as defined in section 13.02, in a manner consistent with this subdivision. This subdivision does not apply to the extent the commissioner is required or permitted by law, or ordered by a court of law to testify or produce evidence in a civil or criminal proceeding. For purposes of this subdivision, a subpoena is not an order of a court of law.

History: *1967 c 395 art 1 s 3; 1969 c 7 s 3; 1969 c 399 s 1; 1969 c 707 s 1; 1969 c 1129 art 4 s 11; 1976 c 2 s 35; 1977 c 305 s 17; 1978 c 470 s 1; 1983 c 289 s 114 subd 1; 1983 c 328 s 2; 1984 c 655 art 1 s 92; 1985 c 248 s 20; 1986 c 444; 1990 c 573 s 19; 1991 c 325 art 10 s 2; 1992 c 540 art 2 s 1; 1992 c 564 art 1 s 14; 1994 c 485 s 5; 1995 c 214 s 2; 2004 c 285 art 4 s 2; 2004 c 290 s 21*

60A.031 EXAMINATIONS.

Subdivision 1. **Power to examine.** (1) **Insurers and other licensees.** At any time and for any reason related to the enforcement of the insurance laws, or to ensure that companies are being operated in a safe and sound manner and to protect the public interest, the commissioner may examine the affairs and conditions of any foreign or domestic insurance or reinsurance company, including reciprocals and fraternals, licensee or applicant for a license under the insurance laws, or any other person or organization of persons doing or in the process of organizing to do any insurance business in this state, and of any licensed advisory organization serving any of the foregoing in this state.

The commissioner shall examine the affairs and conditions of every insurer licensed in this state not less frequently than once every five years.

(2) **Who may be examined.** The commissioner in making any examination of an insurance company as authorized by this section may, if in the commissioner's discretion, there is cause to believe the commissioner is unable to obtain relevant information from such insurance company or that the examination or investigation is, in the discretion of the commissioner, necessary or material to the examination of the company, examine any person, association, or corporation:

(a) transacting, having transacted, or being organized to transact the business of insurance in this state;

(b) engaged in or proposing to be engaged in the organization, promotion, or solicitation of shares or capital contributions to or aiding in the formation of a domestic insurance company;

(c) holding shares of capital stock of an insurance company for the purpose of controlling the management thereof as voting trustee or otherwise;

(d) having a contract, written or oral, pertaining to the management or control of an insurance company as general agent, managing agent, attorney-in-fact, or otherwise;

(e) which has substantial control directly or indirectly over an insurance company whether by ownership of its stock or otherwise, or owning stock in any domestic insurance company, which stock constitutes a substantial proportion of either the stock of the domestic insurance company or of the assets of the owner thereof;

(f) which is a subsidiary or affiliate of an insurance company;

(g) which is a licensed agent or solicitor or has made application for the licenses;

(h) engaged in the business of adjusting losses or financing premiums.

Nothing contained in this clause shall authorize the commissioner to examine any person, association, or corporation which is subject to regular examination by another division of the Commerce Department of this state. The commissioner shall notify the other division when an examination is deemed advisable.

Subd. 2. [Repealed, 1981 c 211 s 42]

Subd. 2a. **Purpose, scope, and notice of examination.** An examination may, but need not, cover comprehensively all aspects of the examinee's affairs, practices, and conditions. The commissioner shall determine the nature and scope of each examination and in doing so shall take into account all available relevant factors concerning the financial and business affairs, practices and conditions of the examinee. For examinations undertaken pursuant to this section, the commissioner shall issue an order stating the scope of the examination and designating the person responsible for conducting the examination. A copy of the order shall be provided to the examinee.

In conducting the examination, the examiner shall observe the guidelines and procedures in the examiner's handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ other guidelines or procedures that the commissioner may consider appropriate.

Subd. 3. **Access to examinee.** (a) The commissioner, or the designated person, shall have timely, convenient, and free access at all reasonable hours to all books, records, securities, accounts, documents, and any or all computer or other records and papers relating to the property, assets, business, and affairs of any company, applicant, association, or person which may be examined pursuant to this section for the purpose of ascertaining, appraising, and evaluating the assets, conditions, affairs, operations, ability to fulfill obligations, and compliance with all the provisions of law of the company or person insofar as any of the above pertain to the business of insurance of a person, organization, or corporation transacting, having

transacted, or being organized to transact business in this state. Every company or person being examined, its officers, directors, and agents, shall provide to the commissioner or the designated person timely, convenient, and free access at all reasonable hours at its office to all its books, records, accounts, papers, securities, documents, any or all computer or other records relating to the property, assets, business, and affairs of the company or person. The officers, directors, and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so.

The refusal of a company, by its officers, directors, employees, or agents, to submit to examination or to comply with a reasonable request of the examiners is grounds for suspension or refusal of, or nonrenewal of, a license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. The proceedings for suspension, revocation, or refusal of a license or authority must be conducted as provided in section 45.027.

(b) The commissioner or any examiners may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. If a person fails or refuses to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(c) When making an examination or audit under this section, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the cost of which must be paid by the company that is the subject of the examination or audit.

(d) This section does not limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to an examination are prima facie evidence in a legal or regulatory action.

(e) Nothing contained in this section shall be construed to limit the commissioner's authority to use as evidence a final or preliminary examination report, examiner or company work papers or other documents, or other information discovered or developed during the course of an examination in the furtherance of a legal or administrative action which the commissioner may, in the commissioner's sole discretion, consider appropriate.

Subd. 4. **Examination report; foreign and domestic companies.** (a) The commissioner shall make a full and true report of every examination conducted pursuant to this chapter, which shall include (1) a statement of findings of fact relating to the financial status and other matters ascertained from the books, papers, records, documents, and other evidence obtained by investigation and examination or ascertained from the testimony of officers, agents, or other persons examined under oath concerning the business, affairs, assets, obligations, ability to fulfill obligations, and compliance with all the provisions of the law of the company, applicant, organization, or person subject to this chapter and (2) a summary of important points noted in the report, conclusions, recommendations and suggestions as may reasonably be warranted from the facts so ascertained in the examinations. The report of examination shall be verified by the oath of the examiner in charge thereof, and shall be prima facie evidence in any action or proceedings in the name of the state against the company, applicant, organization, or person upon the facts stated therein.

(b) No later than 60 days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which provides

the company examined with a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to matters contained in the examination report.

(c) Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with the written submissions or rebuttals and the relevant portions of the examiner's work papers and enter an order:

(1) adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule, or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation;

(2) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refiling the report as required under paragraph (b); or

(3) calling for an investigatory hearing with no less than 20 days' notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(d)(1) All orders entered under paragraph (c), clause (1), must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner work papers, and any written submissions or rebuttals. The order is a final administrative decision and may be appealed as provided under chapter 14. The order must be served upon the company by certified mail, together with a copy of the adopted examination report. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) A hearing conducted under paragraph (c), clause (3), by the commissioner or authorized representative, must be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant work papers or by the written submission or rebuttal of the company. Within 20 days of the conclusion of the hearing, the commissioner shall enter an order as required under paragraph (c), clause (1).

(3) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing must proceed expeditiously. Discovery by the company is limited to the examiner's work papers which tend to substantiate assertions in a written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of witnesses or the production of documents considered relevant to the investigation whether under the control of the department, the company, or other persons. The documents produced must be included in the record. Testimony taken by the commissioner or the commissioner's representative must be under oath and preserved for the record.

This section does not require the department to disclose information or records which would indicate or show the existence or content of an investigation or activity of a criminal justice agency.

(4) The hearing must proceed with the commissioner or the commissioner's representative posing questions to the persons subpoenaed. Thereafter, the company and the department may present testimony relevant to the investigation. Cross-examination may be conducted only by the commissioner or the commissioner's representative. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

(e)(1) Upon the adoption of the examination report under paragraph (c), clause (1), the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of 30 days except as otherwise provided in paragraph (b). Thereafter, the commissioner may open the report for public inspection if a court of competent jurisdiction has not stayed its publication.

(2) Nothing contained in this subdivision prevents or shall be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating to the reports, to the Commerce Department or the insurance department of another state or country, or to law enforcement officials of this or another state or agency of the federal government at any time, if the agency or office receiving the report or matters relating to the report agrees in writing to hold it confidential and in a manner consistent with this subdivision.

(3) If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate proceedings or actions as provided by law.

(f) All working papers, scheduling orders, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this subdivision, or in the course of market analysis, including documents related to scheduling conferences, must be given confidential treatment and are not subject to subpoena and may not be made public by the commissioner or any other person, except to the extent provided in paragraph (e). Access may also be granted to the National Association of Insurance Commissioners (NAIC), the Financial Industry Regulatory Authority, and any national securities association registered under the Securities Exchange Act of 1934. The parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained. For purposes of this section, "market analysis" means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports, such as the NAIC Market Conduct Annual Statement, or other sources in order to develop a baseline profile of an insurer, to review the operation or activity of an insurer, or to identify patterns or practices of insurers licensed to do business in this state that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

(g) Information in the possession or control of, or obtained or disclosed to, the commissioner in the course of, or derived from, market analysis, as defined in paragraph (f), by an insurance company and any scheduling order, supplement to a scheduling order, or document related to a scheduling conference required under section 60A.033 is:

(1) subject to confidential treatment as provided under paragraph (f); and

(2) not subject to subpoena or other discovery nor admissible in evidence in a private civil action. Neither the commissioner nor any person who received information while acting under the authority of the commissioner is permitted or required to testify in a private civil action concerning the information. Nothing in this paragraph limits the ability of the commissioner to use the information in furtherance of an action brought by the commissioner.

(h) Requests for information issued by the commissioner to an insurance company in the course of a market analysis, as defined in paragraph (f), must be issued under the commissioner's authority as provided in this section.

(i) Notwithstanding paragraph (h), the commissioner may request information from an insurance company pursuant to the commissioner's authority under section 45.027, subdivision 1a or 2, if:

(1) the request for information is in connection with an unresolved consumer complaint; or

(2) there is an imminent risk of significant harm to a consumer.

(j) Requests for information from the commissioner to an insurance company under paragraph (i) are not subject to section 60A.033.

Subd. 5. **Order; foreign and domestic companies.** Within a reasonable time of receipt of an examination report the commissioner may issue an order to the examinee directing compliance within a time specified in the order or by law with one or more of the following:

(a) to restore within the time and extent prescribed by law or the commissioner's order any deficiency, whenever its capital, reserves or surplus have become impaired,

(b) to cease and desist from transaction of any business or from any business practice which if transacted or continued might result in the examinee's condition or further transaction of business being hazardous to its policyholders, its creditors, or the public,

(c) to cease and desist from any other violation of its charter or any law of the state.

Subd. 6. **Penalty.** (a) Notwithstanding section 72A.05, any person who violates or aids and abets any violation of a written order issued pursuant to this section may be fined not more than $10,000 for each day the violation continues for each violation of the order and the money so recovered shall be paid into the general fund.

(b) For conduct prohibited under chapters 60A to 79, multiple violations of an identical or substantially similar law, rule, or order shall be considered a single violation under this section and section 45.027. This paragraph does not apply to willful violations by the insurer. This paragraph does not apply to violations that the insurer has not taken corrective action for and that:

(1) cause financial harm to the policyholder;

(2) constitute an unfair method of competition; or

(3) constitute an unfair or deceptive act or practice.

(c) For any applicable penalty imposed by the commissioner under this section, the commissioner must consider whether corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice, and shall reduce or eliminate the penalty accordingly.

(d) This subdivision does not apply if a different penalty is specified under law.

Subd. 7. **Alternatives to examinations.** In lieu of an examination under this section of a foreign or an alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port of entry state until January 1, 1994. After January 1, 1994, the reports may only be accepted if:

(1) the insurance department is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation Program at the time of the examination; or

(2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination

was performed in a manner consistent with the standards and procedures required by their insurance department.

Subd. 7a. **Conflict of interest.** The department shall establish reasonable procedures so that no examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in a person subject to examination under this chapter. This section shall not be construed to automatically preclude an examiner from being:

(1) a policyholder or claimant under an insurance policy;

(2) a grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(3) an investment owner in shares of regulated diversified investment companies; or

(4) a settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

Notwithstanding the requirements of this section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though the persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

Subd. 8. **Power to make rules.** The commissioner may promulgate any rules which may be necessary to the administration of subdivisions 1 to 9.

Subd. 9. **Immunity from liability.** (a) No cause of action shall arise nor shall liability be imposed against the commissioner, the commissioner's authorized representatives, or an examiner appointed by the commissioner for statements made or conduct performed in good faith while carrying out the provisions of this section.

(b) No cause of action shall arise, nor shall liability be imposed against a person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this section, if the act of communication or delivery is performed in good faith and without fraudulent intent or the intent to deceive.

(c) This section does not abrogate or modify a common law or statutory privilege or immunity enjoyed by a person identified in paragraph (a).

(d) A person identified in paragraph (a) may be awarded attorney fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or other relevant tort arising out of activities in carrying out the provisions of this section, and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Subd. 10. **Limitation of enforcement actions or administrative proceedings.** An enforcement action or administrative proceeding brought by the commissioner against a licensee who violates any law, rule, or order related to the duties and responsibilities entrusted to the commissioner in chapters 60A to 79, including without limitation the issuance of an order pursuant to chapters 60A to 79, must be commenced within nine years of the date the violation occurs unless the violation arises out of a contract that remains in force, in which case the action or administrative proceeding must be commenced within two years of the date of the discovery of the violation. If the licensee attempts to conceal a violation, an enforcement action or

administrative proceeding must be brought by the commissioner within nine years of discovery of the violation by the commissioner.

Subd. 11. **Multistate examinations.** If the commissioner elects to participate in an examination of a licensee that involves multiple states, the commissioner is prohibited from commencing, undertaking, or continuing an examination under this section against the subject examinee related to the same alleged conduct, including without limitation incurring or charging any examination costs, unless and until the multistate examination is complete or Minnesota has formally withdrawn from that examination. With respect to any completed multistate examination that Minnesota elected to participate in, the commissioner is prohibited from taking separate action against a licensee that was subject to the multistate examination unless the commissioner follows the procedures set forth in this section and section 60A.033, as applicable.

History: *1967 c 591 s 1; 1969 c 234 s 1,2; 1969 c 399 s 1; 1981 c 211 s 1-7; 1984 c 628 art 3 s 11; 1986 c 444; 1991 c 325 art 10 s 3; 1992 c 540 art 2 s 2; 2004 c 285 art 4 s 3; 2004 c 290 s 22; 2010 c 384 s 4; 2017 c 39 s 1,2; 2020 c 80 art 1 s 14; 2022 c 93 art 2 s 18-20*

60A.032 COMMISSIONER'S ORDERS, REPORT.

When, upon receipt of an examination report, the commissioner forwards to the company an order based on the report, the commissioner shall immediately report the fact to the governor and the attorney general. Within 20 days after submission of the report the commissioner shall submit to the governor and attorney general a supplementary report if the company has not complied with the order.

History: *1969 c 7 s 1; 1986 c 444*

60A.033 SCHEDULING CONFERENCE AND ORDER.

Subdivision 1. **Scope.** This section applies to examinations limited to market analysis, as defined in section 60A.031, subdivision 4, paragraph (f).

Subd. 2. **Scheduling conference required.** Within 30 days of issuing an examination order under section 60A.031, the commissioner must hold a scheduling conference with the insurance company.

Subd. 3. MS 2020 [Repealed, 2022 c 93 art 2 s 43]

Subd. 4. **Scheduling conference.** At the scheduling conference, the commissioner must provide the insurance company with the following:

(1) the justification for the examination and the regulatory issues the examination will address;

(2) the information that must be produced by the insurance company and the timing for its production in accordance with the requirements of subdivision 6;

(3) the estimated length of the examination, subject to the requirements of subdivision 9;

(4) whether contract examiners will be used;

(5) a budget for the exam including:

(i) the daily or hourly rates for the examiners that will be involved in the examination;

(ii) the estimated travel, lodging, meal, and other expenses of the examiners; and

(iii) the estimated administrative and supply costs directly associated with the examination; and

(6) an explanation of the invoicing process and the process for resolving billing disputes.

Subd. 5. **Scheduling order.** Within 15 days following the scheduling conference or as otherwise agreed to by the commissioner and the insurance company, the commissioner must issue a scheduling order that includes the information required by subdivision 4, based on the discussion at the scheduling conference. The commissioner and insurance company must follow the terms of the scheduling order. To amend a scheduling order there must be a supplemental scheduling conference that complies with subdivision 4 and a supplemental scheduling order that complies with this subdivision, unless otherwise agreed upon by the commissioner and the insurance company.

Subd. 6. **Production of information.** (a) Any information requested from an insurance company by the commissioner must:

(1) be limited to matters relevant to the issues the examination will address;

(2) provide the insurance company with a reasonable period of time to respond to the request, but not less than 30 days from the receipt of the request; and

(3) be reasonable in relation to the burden or expense of gathering the requested information and the needs of the examination.

(b) In making an information request, the commissioner must consider whether the information being requested is obtainable from some other source that is more convenient, less burdensome, or less expensive for the insurance company.

(c) An insurance company can extend the time period by which a response to an information request from the commissioner is due by up to 30 days upon giving notice of the extension to the commissioner. The commissioner may extend any time period by which information is due relating to an examination.

Subd. 7. **Conduct of an examination.** (a) Unless required to preserve evidence, the commissioner, department, and examiners:

(1) may not appear at an insurance company's place of business unannounced to conduct the examination; or

(2) may not be present at an insurance company's place of business outside of normal hours without the insurance company's written consent.

(b) If a statement is taken by the commissioner from a person under oath, the person must first be informed of the following:

(1) the scope of the proposed statement;

(2) whether the person is the subject of an examination; and

(3) that the person may be represented by legal counsel during the taking of the statement.

(c) If a statement is taken by the commissioner from a person under oath and the statement is recorded, the person must be provided with a transcript or recording of the statement within 30 days of requesting it from the commissioner.

Subd. 8. **Costs.** All bills for examination costs being charged to an insurance company pursuant to subdivision 5 or section 60A.031, subdivision 3, paragraph (c), must:

(1) be itemized and, with respect to examiner billings, contain activity detail on a quarterly hourly basis by an individual examiner and disclose the applicable hourly billing rates, together with per-charge detail for related travel or other expenses; and

(2) provide a due date no less than 60 days from receipt of the bill.

Subd. 9. **Completion of examination.** An examination under section 60A.031 must not exceed 18 months from the date the commissioner receives the insurance company's first submission pursuant to a scheduling order, unless:

(1) the commissioner determines that there has been a material lack of cooperation by the insurance company and advises the company in writing of the specific instances demonstrating a lack of cooperation;

(2) the examination is a multistate examination; or

(3) the commissioner determines that additional time is necessary to complete the examination and the commissioner notifies the insurance company in writing of the reasons why the examination requires additional time.

Subd. 10. **Hearing; procedure; judicial review.** (a) An insurance company aggrieved by any decision or action of the commissioner under this section as it relates to market analysis may, within 21 days after that decision or action, make a written request to the commissioner for a hearing to determine whether the decision or action complies with the requirements of this section. The commissioner shall hear the party or parties within 21 days after receipt of the request and shall give not less than ten days' written notice of the time and place of the hearing. Within 15 days after the hearing, the commissioner shall affirm, reverse, or modify the previous action and specify the reasons for that decision or action in writing. The effective date of the commissioner's action or decision may be suspended or postponed pending the completion of the hearing before the commissioner.

(b) Nothing contained in this section requires the observance at any hearing of formal rules of pleading or evidence.

(c) An order or decision of the commissioner is a final decision subject to appeal in accordance with chapter 14.

(d) Time used to complete a hearing and appeal under this section must not be counted toward the time frame for completion of an examination under subdivision 9.

Subd. 11. **Informal disposition.** (a) The commissioner must make an attempt to informally resolve any alleged violations of law identified during the examination or investigation. An attempt to informally resolve a violation may consist of a consent order, nonpublic letter of reprimand, or other informal resolution or disposition.

(b) The terms of a consent order or other informal disposition that prescribes compliance requirements must be consistent with the requirements of Minnesota law.

Subd. 12. **Report to the legislature.** Each year by February 1, the commissioner must report the following information to the chairs and ranking minority members of the house of representatives and senate committees having jurisdiction over commerce:

(1) a listing of the number of pending market conduct exams and the year the exams were commenced;

(2) the number of exams closed during the prior year and the current total of costs charged to the companies for each exam;

(3) whether the exam is being conducted, in whole or in part, by third-party examiners; and

(4) other information that the chairs or ranking minority members may reasonably request, subject to the limitations of section 60A.031, subdivision 4, paragraph (f).

History: *2017 c 39 s 3; 2022 c 93 art 2 s 21-24*

60A.035 GOVERNMENT CONTROLLED OR OWNED COMPANY PROHIBITED FROM TRANSACTING BUSINESS.

(a) No insurance company the voting control or ownership of which is held in whole or substantial part by any government or governmental agency or entity having a tax exemption under section 501(c)(27)(B) or 115 of the Internal Revenue Code of 1986 or which is operated for or by any such government or agency or entity having a tax exemption under section 501(c)(27)(B) or 115 of the Internal Revenue Code of 1986 is authorized to transact insurance in this state. Membership in a mutual company, subscribership in a reciprocal insurer, ownership of stock of an insurer by the alien property custodian or similar official of the United States, or supervision of an insurer by public insurance supervisory authority is not considered to be an ownership, control, or operation of the insurer for the purposes of this section.

(b) This section does not apply to an insurance company if its sole insurance business in this state is providing workers' compensation insurance and associated employers' liability coverage to an employer principally located in the insurer's state of domicile whose employee may receive benefits under section 176.041, subdivision 4, provided the operations of the employer are for fewer than 30 consecutive days in this state and provided the employer has no other significant contacts with this state.

(c) This section does not apply to a fund established under section 16B.85, subdivision 2.

History: *1Sp2003 c 1 art 4 s 1*

60A.04 [Repealed, 1969 c 708 s 62]

60A.05 [Repealed, 1992 c 564 art 3 s 30]

60A.051 [Repealed, 1992 c 564 art 3 s 30]

60A.052 CERTIFICATES OF AUTHORITY; ENFORCEMENT ACTIONS.

Subdivision 1. **Grounds.** The commissioner may by order take any or all of the following actions: (a) deny, suspend, or revoke a certificate of authority; (b) censure the insurance company; (c) impose a civil penalty as provided for in section 45.027, subdivision 6; or (d) under a written agreement with the insurance company based upon the company's financial condition, impose conditions or restrictions on the insurance company's authority to transact business in Minnesota. In order to take this action the commissioner must find that the order is in the public interest, and the insurance company:

(1) has a board of directors or principal management that is incompetent, untrustworthy, or so lacking in insurance company managerial experience as to make its operation hazardous to policyholders, its stockholders, or to the insurance buying public;

(2) is controlled directly or indirectly through ownership, management, reinsurance transactions, or other business relations by any person or persons whose business operations are or have been marked by

manipulation of any assets, reinsurance, or accounts as to create a hazard to the company's policyholders, stockholders, or the insurance buying public;

(3) is in an unsound or unsafe condition;

(4) has the actual liabilities that exceed the actual funds of the company;

(5) has filed an application for a license which is incomplete in any material respect or contains any statement which, in light of the circumstances under which it was made, contained any misrepresentation or was false, misleading, or fraudulent;

(6) has pled guilty, with or without explicitly admitting guilt, pled nolo contendere, or been convicted of a felony, gross misdemeanor, or misdemeanor involving moral turpitude, or similar conduct;

(7) is permanently or temporarily enjoined by any court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of the insurance business;

(8) has violated or failed to comply with any order of the insurance regulator of any other state or jurisdiction;

(9) has had a certificate of authority denied, suspended, or revoked, has been censured or reprimanded, has been the subject of any other discipline imposed by, or has paid or has been required to pay a monetary penalty or fine to, another state;

(10) agents, officers, or directors refuse to submit to examination or perform any related legal obligation;

(11) has violated or failed to comply with, any of the provisions of the insurance laws including chapter 45 or chapters 60A to 72A or any rule or order under those chapters; or

(12) has failed to pay the assessment imposed under section 62E.23, subdivision 1a.

Subd. 2. **Suspension or revocation of authority or censure.** If the commissioner determines that one of the conditions listed in subdivision 1 exists, the commissioner may issue an order requiring the insurance company to show cause why any or all of the following should not occur: (1) revocation or suspension of any or all certificates of authority granted to the foreign or domestic insurance company or its agent; (2) censuring of the insurance company; (3) cancellation of all or some of the company's insurance contracts then in force in this state; (4) the imposition of a civil penalty; or (5) under a written agreement with the insurance company based upon the company's financial condition, imposition of conditions or restrictions on the insurance company's authority to transact business in Minnesota. The order shall be calculated to give reasonable notice of the time and place for hearing thereon, and shall state the reasons for the entry of the order. All hearings shall be conducted in accordance with chapter 14. The insurer may waive its right to the hearing. If the insurer is under the supervision or control of the insurance department of the insurer's state of domicile, that insurance department, acting on behalf of the insurer, may waive the insurer's right to the hearing. After the hearing, the commissioner shall enter an order disposing of the matter as the facts require. If the insurance company fails to appear at a hearing after having been duly notified of it, the company shall be considered in default, and the proceeding may be determined against the company upon consideration of the order to show cause, the allegations of which may be considered to be true.

Subd. 3. **Denial; notice to applicant.** Whenever it appears to the commissioner that an application for a certificate of authority should be denied pursuant to subdivision 1, the commissioner shall promptly give a written notice to the applicant of the denial. The notice must state the grounds for the denial and give reasonable notice of the rights of the applicant to request a hearing. A hearing must be held not later than

30 days after the request for hearing is received by the commissioner unless the applicant and the Department of Commerce agree that the hearing may be held at a later date. If no hearing is requested within 30 days of service of the notice, the denial will become final. All hearings shall be conducted in accordance with chapter 14. After the hearing, the commissioner shall enter an order disposing of the matter as the facts require. If the applicant fails to appear at a hearing after having been duly notified of it, the applicant shall be considered in default, and the proceeding may be determined against the applicant upon consideration of the notice denying the application, the allegations of which may be considered to be true.

Subd. 4. **Actions against lapsed certificate of authority.** If a certificate of authority lapses, is surrendered, withdrawn, terminated, or otherwise becomes ineffective, the commissioner may institute a proceeding under this subdivision within two years after the certificate of authority was last effective and enter a revocation or suspension order as of the last date on which the certificate of authority was in effect, or impose a civil penalty as provided for in section 45.027, subdivision 6.

Subd. 4a. **Withdrawal of insurer from state.** No insurer shall withdraw from this state until its direct liability to its policyholders and obligees under all its insurance contracts then in force in this state have been assumed by another licensed insurer according to section 60A.09, subdivision 4a.

History: *1992 c 564 art 3 s 2; 1994 c 425 s 1; 1994 c 485 s 6; 1999 c 177 s 3,4; 2000 c 483 s 2,3; 1Sp2025 c 4 art 6 s 1*

60A.053 MS 2008 [Expired, 2000 c 367 s 1]

60A.06 KINDS OF INSURANCE PERMITTED.

Subdivision 1. **Statutory lines.** Insurance corporations may be authorized to transact in any state or territory in the United States, in the Dominion of Canada, and in foreign countries, when specified in their charters or certificates of incorporation, either as originally granted or as thereafter amended, any of the following kinds of business, upon the stock plan, or upon the mutual plan when the formation of such mutual companies is otherwise authorized by law; and business trusts as authorized by law of this state shall only be authorized to transact in this state the following kind of business hereinafter specified in clause (7) hereof when specified in their "declaration of trust":

(1) To insure against loss or damage to property on land and against loss of rents and rental values, leaseholds of buildings, use and occupancy and direct or consequential loss or damage caused by fire, smoke or smudge, water or other fluid or substance, lightning, windstorm, tornado, cyclone, earthquake, collapse and slippage, rain, hail, frost, snow, freeze, change of temperature, weather or climatic conditions, excess or deficiency of moisture, floods, the rising of waters, oceans, lakes, rivers or their tributaries, bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, electrical power interruption or electrical breakdown from any cause, railroad equipment, motor vehicles or aircraft, accidental injury to sprinklers, pumps, conduits or containers or other apparatus erected for extinguishing fires, explosion, whether fire ensues or not, except explosions on risks specified in clause (3); provided, however, that there may be insured hereunder the following: (a) explosion of any kind originating outside the insured building or outside of the building containing the property insured; (b) explosion of pressure vessels which do not contain steam or which are not operated with steam coils or steam jackets; and (c) risks under home owners multiple peril policies;

(2)(a) To insure vessels, freight, goods, wares, merchandise, specie, bullion, jewels, profits, commissions, bank notes, bills of exchange, and other evidences of debt, bottomry and respondentia interest, and every insurance appertaining to or connected with risks of transportation and navigation on and under water, on land or in the air;

(b) To insure all personal property floater risks;

(3) To insure against any loss from either direct or indirect damage to any property or interest of the assured or of another, resulting from the explosion of or injury to (a) any boiler, heater or other fired pressure vessel; (b) any unfired pressure vessel; (c) pipes or containers connected with any of said boilers or vessels; (d) any engine, turbine, compressor, pump or wheel; (e) any apparatus generating, transmitting or using electricity; (f) any other machinery or apparatus connected with or operated by any of the previously named boilers, vessels or machines; and including the incidental power to make inspections of and to issue certificates of inspection upon, any such boilers, apparatus, and machinery, whether insured or otherwise;

(4) To make contracts of life and endowment insurance, to grant, purchase, or dispose of annuities or endowments of any kind; and, in such contracts, or in contracts supplemental thereto to provide for additional benefits in event of death of the insured by accidental means, total permanent disability of the insured, or specific dismemberment or disablement suffered by the insured, or acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable;

(5)(a) To insure against loss or damage by the sickness, bodily injury or death by accident of the assured or dependents, or those for whom the assured has assumed a portion of the liability for the loss or damage, including liability for payment of medical care costs or for provision of medical care;

(b) To insure against the legal liability, whether imposed by common law or by statute or assumed by contract, of employers for the death or disablement of, or injury to, employees;

(6) To guarantee the fidelity of persons in fiduciary positions, public or private, or to act as surety on official and other bonds, and for the performance of official or other obligations;

(7) To insure owners and others interested in real or personal property as described in section 68A.04;

(8) To insure against loss or damage by breakage of glass, located or in transit;

(9)(a) To insure against loss by burglary, theft, or forgery;

(b) To insure against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptance or any other valuable paper or document, resulting from any cause, except while in the custody or possession of and being transported by any carrier for hire or in the mail;

(c) To insure individuals by means of an all risk type of policy commonly known as the "personal property floater" against any kind and all kinds of loss of or damage to, or loss of use of, any personal property other than merchandise;

(d) To insure against loss or damage by water or other fluid or substance;

(10) To insure against loss from death of domestic animals and to furnish veterinary service;

(11) To guarantee merchants and those engaged in business, and giving credit, from loss by reason of giving credit to those dealing with them; this shall be known as credit insurance;

(12) To insure against loss or damage to automobiles or other vehicles or aircraft and their contents, by collision, fire, burglary, or theft, and other perils of operation, and against liability for damage to persons, or property of others, by collision with such vehicles or aircraft, and to insure against any loss or hazard incident to the ownership, operation, or use of motor or other vehicles or aircraft;

(13) To insure against liability for loss or damage to the property or person of another caused by the insured or by those for whom the insured is responsible, including insurance of medical, hospital, surgical, funeral or other related expense of the insured or other person injured, irrespective of legal liability of the insured, when issued with or supplemental to policies of liability insurance;

(14) To insure against loss of or damage to any property of the insured, resulting from the ownership, maintenance or use of elevators, except loss or damage by fire;

(15) To insure against attorneys fees, court costs, witness fees and incidental expenses incurred in connection with the use of the professional services of attorneys at law.

Subd. 2. **Other lines.** Any insurance corporation or association heretofore or hereafter licensed to transact within the state any of the kinds or classes of insurance specifically authorized under the laws of this state may, when authorized by its charter, transact within and without the state any lines of insurance germane to its charter powers and not specifically provided for under the laws of this state when these lines, or combinations of lines, of insurance are not in violation of the constitution or the laws of the state and, in the opinion of the commissioner, not contrary to public policy, provided the company or association shall first obtain authority of the commissioner and meet capital or surplus and other solvency and policy form requirements as the commissioner shall prescribe. These additional hazards may be insured against by attachment to, or in extension of, any policy which the company may be authorized to issue under the laws of this state. This subdivision shall apply to companies operating upon the stock or mutual plan, reciprocal or interinsurance exchanges.

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

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

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

(d) This subdivision does not prohibit combining life coverage with one or more of the following coverages:

(1) specified disease or illness coverage;

(2) other limited benefit health coverage;

(3) hospital indemnity coverage;

(4) other fixed indemnity products,

provided that the prescribed minimum standards applicable to those categories of coverage are met.

Subd. 4. **Vicarious liability; punitive damages.** Any insurance corporation or association may insure against vicarious liability for punitive and exemplary damages within any of the kinds of business pertaining

to the issuance of liability insurance that the insurance corporation or association is authorized to transact under subdivision 1 or 2.

History: *1967 c 395 art 1 s 6; 1969 c 7 s 5; 1973 c 634 s 1; 1986 c 444; 1986 c 455 s 4; 1989 c 125 s 1,2; 1995 c 258 s 1; 1999 c 177 s 5,6; 2000 c 304 s 1; 2001 c 215 s 1; 2008 c 347 s 1; 2011 c 108 s 9*

60A.07 AUTHORIZATION AND REQUIREMENTS.

Subdivision 1. **Incorporation.** Three or more persons may form a domestic insurance corporation for any of the purposes specified in subdivision 2 by applying to the Department of Commerce and complying with all applicable organizational requirements and the conditions set out in clauses (1) to (6). The incorporators must subscribe a certificate specifying:

(1) the corporation's name, which must distinguish it from all other corporations authorized to do business in this state, and must contain the word "company," "corporation," or "incorporated";

(2) the general nature of the corporation's business and its principal place of business;

(3) the period of its duration, if limited;

(4) the names and places of residence of the incorporators;

(5) the board in which the management of the corporation will be vested, the date of the initial annual meeting at which it will be elected, and the names and addresses of the board members until the first election; and

(6) whether the corporation is organized on the stock plan, mutual plan, or otherwise; and, if organized as a stock company, the amount of capital stock, how the capital stock is to be paid in, the number of shares into which it is to be divided, and the par value of each share; and, if there is to be more than one class, a description and the terms of issue of each class and the method of voting on each class.

The certificate may contain any other lawful provision defining and regulating the powers and business of the insurance corporation, its officers, directors, trustees, members, or stockholders.

Domestic insurance corporations established in this manner are organized under and governed by chapter 302A, except as otherwise provided in subdivision 1d and chapter 66A.

Subd. 1a. MS 2018 [Repealed, 2020 c 80 art 1 s 29]

Subd. 1b. **Certificate of authority.** If the commissioner of commerce is satisfied that the corporation has been organized for legitimate purposes, and under such conditions as to merit and have public confidence, and that all provisions of law applicable to every branch of business in which, by the terms of its certificate, it is authorized to engage, have been complied with, the commissioner shall so certify. When the original certificate and the certificate of incorporation from the secretary of state are filed with the commissioner of commerce, the commissioner shall, within 60 days thereafter, execute and deliver to it a certificate of authority.

Subd. 1c. **Bylaws.** Bylaws may be adopted by the insurance corporation in the manner set forth in section 302A.181. Within 90 days after the adoption of the bylaws or any amendment thereof, a certified copy of the same must be filed with the commissioner of commerce.

Subd. 1d. **Certificate of incorporation; amendments.** The certificate of incorporation of an insurance corporation organized and existing under the laws of this state may be amended in the manner set forth in section 302A.135. Amendments are effective upon the commissioner's approval.

Subd. 1e. **Application of business corporation act.** The provisions of chapter 302A apply to domestic stock corporations formed to carry on the business of insurance, except to the extent those provisions are inconsistent with any provisions contained in this chapter or to the extent in conflict with any provisions contained in chapters 60A to 79A. The provisions of chapter 302A apply to domestic mutual corporations formed to carry on the business of insurance only to the extent provided for in chapter 66A.

Subd. 2. **Powers of insurers.** Corporations may be formed for carrying on any one branch of the business of insurance authorized by law, or any two or more branches thereof, which are permitted by law to be transacted by one company; and business trusts as authorized by law of this state may be formed for carrying on the kind of business of insurance specified in section 60A.06, subdivision 1, clause (7).

Subd. 3. **Acceptance of laws.** Every company, domestic or foreign, shall file with the commissioner its acceptance of the provisions of the insurance laws of the state of Minnesota, and its charter and any amendments thereto, and each such company shall be governed thereby and by those laws relative to corporations in general, so far as applicable and not otherwise specifically provided. No foreign company shall be denied a license in this state because its corporate powers exceed those which it is permitted to exercise under the laws of this state, but no foreign company, which does outside of this state any kind or combination of kinds of insurance not permitted to be done in this state by similar domestic companies, now or hereafter organized, shall be or continue to be authorized to do an insurance business in this state if the commissioner of commerce finds, after ten days' notice sent by certified mail to the home office of the company involved, and an opportunity to be heard, that the doing of such kind or combination of kinds of insurance business impairs the financial solvency of the company or its financial ability to meet its obligations incurred in this state, or finds that the doing of such kinds or combination of kinds of insurance business is prejudicial to the interests of policyholders, creditors or the people of this state.

Subd. 4. **License required.** No insurance company or association, or fraternal benefit society, not specifically exempted therefrom by law, shall transact the business of insurance in this state unless it shall hold a license therefor from the commissioner.

Subd. 5. [Repealed, 1969 c 7 s 6]

Subd. 5a. **Financial requirements; stock companies.** No insurance company operating upon the stock plan shall be initially authorized to transact any one of the kinds of business enumerated in section 60A.06, subdivision 1, clauses (1) to (15), unless it shall have paid-up capital stock and surplus of not less than the amounts specified below. Except as otherwise provided by this subdivision, after initial authorization has been granted, surplus shall be constantly maintained in an amount not less than one-half of the surplus originally required for that kind of business. If the kind of business being transacted is of the type authorized by section 60A.06, subdivision 1, clause (4), surplus shall be constantly maintained after initial authorization in an amount not less than 25 percent of the amount of surplus originally required.

	Paid Up Capital Stock	Surplus
Clause (1),	$350,000	$350,000
Clause (2),	$350,000	$350,000

Clause (3),	$200,000	$200,000
Clause (4),	$1,000,000	$2,000,000
Clause (5)(a),	$500,000	$1,000,000
Clause (5)(b),	$500,000	$1,000,000
Clause (6),	$500,000	$500,000
Clause (7),	$500,000	$500,000
Clause (8),	$200,000	$200,000
Clause (9),	$200,000	$200,000
Clause (10),	$200,000	$200,000
Clause (11),	$350,000	$700,000
Clause (12),	$500,000	$1,000,000
Clause (13),	$500,000	$1,000,000
Clause (14),	$200,000	$200,000
Clause (15),	$350,000	$350,000

Subd. 5b. **Financial requirements; mutual companies.** No insurance company operating upon the mutual plan as provided in chapter 66A, shall be authorized to transact any one of the kinds of business enumerated in section 60A.06, subdivision 1, clauses (1) to (3) and (5) to (15), unless in addition to the requirements specified in chapter 66A it shall have met the following requirements as to surplus: As to a mutual company operating on a nonassessable basis, an initial surplus of not less than the amount of surplus enumerated in subdivision 5a for a stock company authorized to transact that kind of business, provided that after initial authorization has been granted, the surplus shall thereafter be constantly maintained in an amount equal to not less than one-half of such initial surplus; as to a mutual company operating on an assessable basis, an initial surplus of not less than one-half of the amount of surplus enumerated in subdivision 5a for a stock company authorized to transact that kind of business, provided that after initial authorization has been granted, the surplus shall thereafter be constantly maintained in an amount equal to not less than one-half of such initial surplus.

No insurance company operating upon the mutual plan shall be authorized to transact the kind of business enumerated in section 60A.06, subdivision 1, clause (4), unless it shall have surplus of not less than $3,000,000; provided that after initial authorization has been granted, the surplus shall thereafter be constantly maintained in an amount of not less than $1,500,000.

No insurance company operating upon the mutual plan, other than as provided in chapter 66A, shall be authorized to transact the kind of business enumerated in section 60A.06, subdivision 1, clause (5)(a), unless it shall have a surplus of not less than $1,500,000; provided that after initial authorization has been granted, the surplus thereafter shall be constantly maintained in the amount of not less than $1,000,000.

Subd. 5c. **Authorization to transact more than one kind of business.** Any insurance corporation authorized to transact the kinds of business specified in section 60A.06, subdivision 1, clause (4), may also transact the kinds of business specified in section 60A.06, subdivision 1, clause (5)(a), upon meeting the

following financial requirements: As to companies operating upon the stock plan, paid-up capital stock of not less than $1,000,000 and an initial surplus of not less than $2,000,000 which surplus shall thereafter be constantly maintained in the amount of not less than $500,000; as to companies operating on the mutual plan, an initial surplus of not less than $3,000,000 which shall thereafter be constantly maintained in the amount of not less than $1,500,000.

Any insurance corporation which prior to January 1, 1949, was authorized to transact personal injury liability insurance and also the kinds of business specified in section 60A.06, subdivision 1, clauses (4) and (5), shall continue to be authorized to transact personal injury liability insurance, providing the corporation continues to meet the revised financial requirements of this subdivision.

Any stock company may, when authorized by its articles of incorporation, transact any two or more of the kinds of business specified in section 60A.06, subdivision 1, clauses (1) to (3) and (5) to (15), upon meeting the following financial requirements: paid-up capital stock of not less than $1,000,000 and an initial surplus of not less than $1,000,000 which surplus shall thereafter be constantly maintained in the amount of not less than $500,000; provided, however, that if the sum of the capital stock and surplus requirements specified in subdivision 5a for the kinds of business to be transacted is less than the amount of the capital stock and surplus requirements stated in the foregoing clauses of this sentence, then the company may transact those kinds of business upon meeting the capital stock and surplus requirements specified in subdivision 5a for those kinds of business. Any insurance company operating upon the mutual plan as provided in chapter 66A, may, when authorized by its articles of incorporation, transact any two or more of the kinds of business specified in section 60A.06, subdivision 1, clauses (1) to (3) and (5) to (15), upon meeting the following requirements as to surplus which shall be in addition to the requirements specified in chapter 66A: as to mutual companies operating on a nonassessable basis, an initial surplus of not less than $1,000,000, which surplus shall thereafter be constantly maintained in the amount of not less than $500,000; as to mutual companies operating on an assessable basis, an initial surplus of not less than $750,000, which surplus shall thereafter be constantly maintained in the amount of not less than $375,000; provided, however, that if the sum of the surplus requirements specified in subdivisions 5a and 5b for the kinds of business to be transacted is less than the amount of the surplus requirements stated in the foregoing clauses of this sentence, then the company may transact those kinds of business upon meeting the surplus requirements specified in subdivisions 5a and 5b for those kinds of business.

Subd. 5d. [Repealed, 1993 c 299 s 33]

Subd. 5e. **Minimum requirements; deficiency.** Whenever the commissioner finds that the capital or surplus of a stock company, or the surplus of a mutual company, is less than the minimum requirements prescribed by this section and sections 66A.32 and 66A.33, the commissioner shall determine the amount of the deficiency and issue an order in writing requiring the insurance company to restore the deficiency within such reasonable period as the commissioner shall designate. The commissioner may, by order served upon the insurance company, prohibit the insurance company from issuing any new policies while the deficiency exists. If at the expiration of the designated period the insurance company has not restored the deficiency and filed proof satisfactory to the commissioner, the commissioner shall proceed against the insurance company as provided in chapter 60B; provided, however, that if the surplus of a mutual company operating on the nonassessable basis declines below the minimum requirement prescribed by this section and sections 66A.32 and 66A.33 for such a company, and if its surplus is equal to or greater than the minimum requirement for a mutual company operating on the assessable basis, it may continue to write on the assessable basis by issuing only assessable policies.

Subd. 5f. **Capital and surplus requirements.** (a) Capital and surplus requirements apply to all types of insurance transacted by the insurer, whether or not only a portion of the types of insurance are transacted

in this state. The commissioner may for the protection of the public require an insurer to maintain funds in excess of the amounts required under this section and sections 66A.32 and 66A.33, due to the amount, kind, or combination of types of insurance transacted by the insurer. Failure of an insurer to maintain funds as ordered by the commissioner is grounds for suspension or revocation of the insurer's certificate of authority.

(b) After June 30, 1991, an insurer may not renew and continue its certificate of authority unless the insurer possesses at least the basic capital and surplus, and additional surplus required by the commissioner under this section and sections 66A.32 and 66A.33.

Subd. 6. **Reduction of capital stock.** When the capital of any domestic stock company is impaired, it may, upon a vote of the majority of the stock, reduce the same to not less than the legal minimum. In this case no part of its assets shall be distributed to the stockholders. Any such company whose capital is not impaired may, by a two-thirds vote of its stock and with the consent of the commissioner, reduce the same to not less than the legal minimum capital and surplus required for such a company. In either case, within ten days after the meeting at which the reduction was made, the company shall submit to the commissioner a certified statement of the proceedings thereof, including the amount of the reduction and its assets and liabilities, verified by its president, secretary, and a majority of its directors. The commissioner shall examine the facts and, if they conform to law and the commissioner is of opinion that injury to the public will not result, the commissioner shall endorse approval upon the statement. Upon filing the same with the secretary of state and paying a filing fee of $5, and duly amending its certificate of incorporation in conformity therewith, it may transact business upon the reduced capital as though the same were its original capital, and the commissioner shall issue a license to that effect. The company may thereafter, by a majority vote of its directors, require the return of every original stock certificate in exchange for a new certificate for such number of shares as each stockholder is entitled to, in the proportion that the reduced capital bears to the original.

Subd. 7. **New certificate of authority.** Upon application, the commissioner shall examine the proceedings of any domestic company to increase or reduce its capital stock and, when found conformable to law, shall revoke the old and issue a new certificate of authority to the company to transact business upon the increased or reduced capital.

Subd. 8. [Repealed, 2005 c 69 art 2 s 19]

Subd. 9. **Retaliatory provision.** When the laws of any other state, territory, or country prohibit the organization of or do not provide for the organization of or the licensing in that state, territory, or country of a class or kind of insurance companies or associations organized under the laws of this state and authorized to transact the business of insurance in this state, then companies or associations of the same kind or class of the other state, territory, or country shall not be licensed to do business in this state.

This provision shall not apply to companies or associations, organized under the laws of another state, now licensed to do business in this state.

Subd. 10. [Clause (1) renumbered 66A.32]

[Clause (2) renumbered 66A.33]

Subd. 11. **Officers and employees bonded.** Every company shall provide a fidelity bond for its officers and employees. The bond shall be in the amount deemed necessary by the commissioner to adequately protect the public.

History: *1967 c 395 art 1 s 7; 1969 c 7 s 7-13; 1969 c 598 s 1; 1969 c 708 s 63; 1973 c 634 s 2-4; 1976 c 213 s 1-4; 1978 c 465 s 1,2; 1978 c 674 s 60; 1980 c 516 s 2; 1983 c 216 art 1 s 15; 1983 c 289 s 114*

subd 1; 1984 c 655 art 1 s 92; 1986 c 313 s 2; 1986 c 444; 1991 c 325 art 10 s 4; art 14 s 1; 1992 c 564 art 1 s 15,16,54; 1995 c 214 s 3; 1996 c 446 art 2 s 1,2; 2005 c 69 art 2 s 1-6, 18; 2008 c 203 s 3; 2020 c 80 art 1 s 15

60A.071 SUBSTANTIAL ENROLLMENT GROWTH; NOTIFICATION.

Subdivision 1. **Notice required.** (a) No later than April 15 each year, an insurance company that issues health plans, as defined in section 62A.011, and is licensed under this chapter to offer, sell, or issue a policy of accident and sickness insurance, as defined in section 62A.01, subdivision 1, or that is a nonprofit health service plan corporation operating under chapter 62C must notify the commissioner if, for an insurance company or nonprofit health service plan corporation with at least 25,000 enrollees, the insurance company or nonprofit health service plan corporation:

(1) increases the total number of enrollees, as of April 1 in the current calendar year, by more than 35 percent of the insurance company's or nonprofit health service plan corporation's total number of enrollees for the immediately preceding calendar year; or

(2) increases the total number of enrollees in a specific line of business or product by a percentage that is greater than the percentage of growth threshold established by the commissioner for the specific line of business or product.

(b) For purposes of this section, the number of enrollees must be calculated in a manner consistent with the insurance company or nonprofit health service plan corporation's reported covered lives in the company's National Association of Insurance Commissioners Annual Statement.

Subd. 2. **Additional information.** (a) Upon receiving notice under subdivision 1, the commissioner may request and the insurance company or nonprofit health service plan corporation must provide additional information regarding the insurance company's or nonprofit health service plan corporation's financial readiness to serve the increased enrollment. The additional information requested may include but is not limited to:

(1) the conditions contributing to the insurance company's or nonprofit health service plan corporation's enrollment growth;

(2) a three-year projected statutory balance sheet, income statements, and cash flow statements for the current year and the subsequent two years;

(3) the key assumptions impacting the projections and the sensitivity of the projections to the assumptions; and

(4) a description of anticipated issues associated with the insurance company's or nonprofit health service plan corporation's business, including but not limited to (i) assets, (ii) anticipated business growth and associated surplus strain, (iii) significant change in risk profile, (iv) mix of business, and (v) reinsurance use, if any, in each case.

(b) If the information reported under paragraph (a) raises a concern with respect to an insurance company's or nonprofit health service plan corporation's business on a prospective basis due to anticipated business growth, including but not limited to anticipated business growth, strain on surplus, increased exposure to risk, or an imbalanced mix of business, the commissioner may issue a corrective order specifying corrective

actions the commissioner determines are required. A corrective order issued under this paragraph is subject to review under chapter 14.

History: *2026 c 124 art 3 s 1*

60A.075 [Renumbered 66A.41]

60A.076 [Repealed, 1991 c 325 art 4 s 10]

60A.077 [Renumbered 66A.40]

INSURABLE INTEREST

60A.078 SHORT TITLE.

Sections 60A.078 to 60A.0789 may be cited as the "Insurable Interest Act."

History: *2009 c 52 s 1*

60A.0782 DEFINITIONS.

Subdivision 1. **Terms.** For the purpose of sections 60A.078 to 60A.0789, unless the context clearly indicates otherwise, the terms in this section have the meanings given them.

Subd. 2. **Act.** "Act" means sections 60A.078 to 60A.0789.

Subd. 3. **Business entity.** "Business entity" includes, but is not limited to, a joint venture, partnership, corporation, limited liability company, and business trust.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 5. **Legitimate settlement contracts.** "Legitimate settlement contracts" mean settlement contracts that comply with Minnesota law governing viatical settlement contracts and that are not prohibited by section 60A.0785 or otherwise part of or in furtherance of an act, practice, or arrangement that is prohibited by sections 60A.078 to 60A.0789.

Subd. 6. **Life expectancy evaluation.** "Life expectancy evaluation" means an evaluation conducted by any person other than the insurer or its authorized representatives for the purpose of projecting or estimating how long a particular individual is expected to live.

Subd. 7. **Person.** "Person" means any natural person or legal entity, including, but not limited to, a partnership, limited liability company, association, trust, or corporation.

Subd. 8. **Policy.** "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

Subd. 9. **Policyowner.** "Policyowner" means the owner of a policy.

Subd. 10. **Prospective purchaser.** "Prospective purchaser" means any person that may purchase or acquire the policy or a beneficial interest in the policy, but excluding individuals closely related to the insured by blood or law or who have a lawful and substantial interest in the continued life of the insured, or trusts established for the benefit of those individuals, provided those trusts meet the requirements of section 60A.0783, subdivision 2, paragraph (d).

Subd. 11. **Settlement contract.** (a) "Settlement contract" means an agreement between a policyowner and another person establishing the terms under which compensation or anything of value will be paid or which compensation or value is less than the expected death benefit of the insurance policy, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the policy. Settlement contract also includes:

(1) the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such a policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more policies, which policy insures the life of an individual who is a resident of this state; and

(2) a premium finance loan made for a policy by a lender to a policyowner on, before, or after the date of issuance of the policy where:

(i) the policyowner or the insured receives a guarantee of a future settlement value of the policy; or

(ii) the policyowner or the insured agrees to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(b) Settlement contract does not include:

(1) a policy loan or accelerated death benefit made by the insurer under the policy's terms;

(2) loan proceeds that are used solely to pay premiums for the policy and loan-related costs, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(3) a loan made by a bank or other licensed financial institution in which the lender takes an interest in a policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, as long as the default itself is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under sections 60A.078 to 60A.0789;

(4) an agreement in which all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured or are trusts established for the benefit of such parties;

(5) any designation, consent, or agreement by an insured who is an employee or an employer in connection with the purchase by the employer, or by a trust established by the employer, of life insurance on the life of the employee;

(6) a bona fide business succession planning arrangement:

(i) between shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders;

(ii) between partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partner; or

(iii) between members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members; or

(7) an agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business.

Subd. 12. **Stranger-originated life insurance practices.** "Stranger-originated life insurance practices" or "STOLI practices" means an act, practice, or arrangement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person or entity, who, at the time of policy inception, could not lawfully initiate the policy themselves, and where, at the time of inception, there is an arrangement or agreement, whether spoken or written, to directly or indirectly transfer the ownership of the policy and/or the policy benefits to a third party. Trusts that are created to give the appearance of insurable interest and are used to initiate policies for investors violate the insurable interest requirements and the prohibition against STOLI practices.

History: *2009 c 52 s 2*

60A.0783 INSURABLE INTEREST REQUIRED.

Subdivision 1. **Insurance on life of another.** A person may not procure or cause to be procured or effected a policy upon the life of another individual unless the benefits under the policy are payable to the insured, the personal representatives of the insured's estate, or to a person having, at the time the policy is issued, an insurable interest in the individual insured.

Subd. 2. **What constitutes an insurable interest.** Insurable interest, with reference to insurance on the life of another, includes only the following interests.

(a) An individual has an insurable interest in the life of another person to whom the individual is closely related by blood or by law and in whom the individual has a substantial interest engendered by love and affection.

(b) An individual has an insurable interest in the life of another person if such individual has a lawful and substantial interest in the continued life of the individual insured, as distinguished from an interest that would arise only by or would be enhanced in value by the death of the individual insured.

(c) An individual party to a contract for the purchase or sale of an interest in any business entity and, if applicable, a trust or the trustee of a trust of which the individual is a settlor, has an insurable interest in the life of each other individual party to the contract, but only for the purpose of carrying out the intent and purpose of the contract.

(d) A trust, or the trustee of a trust, has an insurable interest in the life of an individual insured under a life insurance policy owned by the trust, or the trustee of the trust acting in a fiduciary capacity, if the insured is the settlor of the trust; an individual closely related by blood or law to the settlor; or an individual in whom the settlor otherwise has an insurable interest if, in each of the situations described in this paragraph, the life insurance proceeds are primarily for the benefit of trust beneficiaries having an insurable interest in the life of the insured and the trust is not used, directly or indirectly, as part of or in furtherance of an act, practice, or arrangement that is otherwise prohibited by sections 60A.078 to 60A.0789.

(e) A guardian, trustee, or other fiduciary, acting in a fiduciary capacity, has an insurable interest in the life of any person for whose benefit the fiduciary holds property, and in the life of any other individual in whose life the person has an insurable interest so long as the life insurance proceeds are used primarily for the benefit of persons having an insurable interest in the life of the insured and the guardianship or fiduciary

relationship is not used, directly or indirectly, as part of or in furtherance of an act, practice, or arrangement that is otherwise prohibited by sections 60A.078 to 60A.0789.

(f) An organization in section 170(c) of the United States Internal Revenue Code of 1986, as amended through December 31, 2008, has an insurable interest in the life of any person who consents in writing to the organization's ownership or purchase of that insurance.

(g) A trustee, sponsor, or custodian of assets held in any plan governed by the Employee Retirement Income Security Act of 1974, United States Code, title 29, section 1001, et seq., or in any other retirement or employee benefit plan, has an insurable interest in the life of any participant in the plan provided consent is obtained in writing from the participant before the insurance is purchased. An employer, trustee, sponsor, or custodian may not retaliate or take adverse action against any participant who does not consent to the issuance of insurance on the participant's life.

(h) A business entity has an insurable interest in the life of any of the owners, directors, officers, partners, and managers of the business entity or any affiliate or subsidiary of the business entity, or key employees or key persons of the business entity or affiliate or subsidiary, provided consent is obtained in writing from key employees or persons before the insurance is purchased. The business entity or affiliate or subsidiary may not retaliate or take adverse action against any key employee or person who does not consent to the issuance of insurance on the key employee or key person's life. For purposes of this subdivision, a "key employee" or "key person" means an individual whose position or compensation is described in section 101(j)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended through December 31, 2008.

(i) A financial institution or other person to whom a debt is owed, whether for the purposes of premium financing or otherwise, has an insurable interest in the life of the borrower limited to the amount of debt owed plus reasonable interest and service charges.

Subd. 3. **Insured's own life.** An individual has an insurable interest in the individual's own life and an individual of competent legal capacity that procures or effects a policy on the individual's own life may designate any person as the beneficiary, provided the policy is not part of or in furtherance of an act, practice, or arrangement that is otherwise prohibited by sections 60A.078 to 60A.0789.

Subd. 4. **Reliance on statements.** An insurer is entitled to rely upon all reasonable statements, declarations, and representations made by an applicant for life insurance relative to the existence of an insurable interest; and no insurer shall incur legal liability, except as set forth in the policy, by virtue of untrue statements, declarations, or representations so relied upon in good faith by the insurer.

Subd. 5. **Consent of insured.** A policy upon the life of an individual, other than a policy of noncontributory group life insurance, may not be effectuated unless, on or before the time the policy is effectuated, the individual insured, having legal capacity to contract, applies for or consents in writing to the policy and its terms. Consent may be given by another in the following cases:

(1) a parent or a person having legal custody of a minor may consent to the issuance of a policy on a dependent child;

(2) a court-appointed guardian of a person may consent to the issuance of a policy on the person under guardianship;

(3) a court-appointed conservator of a person's estate may consent to the issuance of a policy on the person whose estate is under conservatorship;

(4) an attorney-in-fact may consent to the issuance of a policy on the person that appointed the attorney-in-fact for the limited purpose of replacing one or more policies with one or more new policies, provided the aggregate amount of life insurance on the person as the result of the replacement remains the same or decreases;

(5) a trustee of a revocable trust may consent to the issuance of a policy on the life of a settlor of the trust; and

(6) a court of general jurisdiction may give consent to the issuance of a policy upon a showing of facts the court considers sufficient to justify the issuance of the policy.

History: *2009 c 52 s 3*

60A.0784 PROHIBITED PRACTICES.

It is unlawful for any person to:

(1) procure or cause to be procured or effected a policy in violation of section 60A.0783;

(2) engage in STOLI practices or otherwise wager on life;

(3) solicit, market, or otherwise promote the purchase of a policy for the purpose of or with an emphasis on the subsequent sale of the policy in the secondary market;

(4) enter into a premium finance agreement with any person or agency, or any person affiliated with such person or agency, pursuant to which the lender or any person affiliated with the lender shall receive any proceeds, fees, or other consideration, directly or indirectly, from the policy or policyowner or any other person with respect to the premium finance agreement or any settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of such agreement; provided, further, that any payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums paid under the premium finance agreement shall be remitted to the insured or to the insured's estate if the insured is not living at the time of the determination of the overpayment; or

(5) enter into or to offer to enter into a settlement contract prior to the issuance of a policy that is the subject of the settlement contract or proposed settlement contract.

History: *2009 c 52 s 4*

60A.0785 PROHIBITION; ENTRY INTO SETTLEMENT CONTRACTS.

Subdivision 1. **Prohibition.** No prospective purchaser of the policy or beneficial interest in the policy shall, at any time prior to issuance of a policy, or during a four-year period commencing with the date of issuance of the policy, enter into a settlement contract or any other agreement the effect of which is to acquire the policy or a beneficial interest in the policy regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest, or surrender of the policy or beneficial interest in the policy is to occur, unless and until the prospective purchaser has determined, based on reasonable inquiry, which includes but is not limited to questioning the insured and reviewing the broker's files, that none of the following circumstances are present:

(1) there was an agreement or understanding, before issuance of the policy, between the insured, policyowner, or owner of a beneficial interest in the policy, and another person to guarantee any liability or

to purchase, or stand ready to purchase, the policy or an interest therein, including through an assumption or forgiveness of a loan; or

(2) both of the following are present:

(i) all or a portion of the policy premiums were funded by means other than by the insured's personal assets or assets provided by a person who is closely related to the insured by blood or law or who has a lawful and substantial economic interest in the continued life of the insured. For purposes of this provision, funds from a premium finance loan are considered assets of the insured or such person only if the insured or such person is contractually obligated to repay the full amount of the loan and to pledge personal assets, other than the policy itself, for loan amounts exceeding the policy's cash value; and

(ii) the insured underwent a life expectancy evaluation within the 18-month time period immediately prior to the issuance of the policy and, during the same time period, the results of the life expectancy evaluation were shared with or used by any person for the purpose of determining the actual or potential value of the policy in the secondary market. Nothing in this paragraph shall prevent such a life expectancy evaluation from being shared with or used by the insured or the insured's accountant, attorney, or insurance producer for estate planning purposes so long as the life expectancy evaluation is not used by such persons to determine the actual or potential value of the policy in the secondary market.

Subd. 2. **Certification.** As part of the prospective purchaser's responsibility to make reasonable inquiry, the prospective purchaser shall request, and the settlement broker shall provide, a certification in which the broker certifies that, to the best of the broker's knowledge, any life expectancy evaluation performed on the insured prior to the issuance of the policy was not used by or shared with any other person prior to the issuance of the policy for the purpose of determining the actual or potential value of the policy in the secondary market.

Subd. 3. **Legitimate insurance transactions.** Nothing in sections 60A.078 to 60A.0789 prevents:

(1) any policyowner, whether or not the policyowner is also the subject of the insurance, from entering into a legitimate settlement contract;

(2) any person from soliciting a person to enter into a legitimate settlement contract;

(3) a person from enforcing the payment of proceeds from the interest obtained under a legitimate settlement contract; or

(4) the assignment, sale, transfer, devise, or bequest with respect to the death benefit or ownership of any portion of a policy, provided the assignment, sale, transfer, devise, or bequest is connected to a legitimate settlement contract and not part of or in furtherance of STOLI practices.

History: *2009 c 52 s 5*

60A.0786 PRESUMPTION OF STOLI PRACTICES.

Subdivision 1. **Presumption of STOLI practices.** A settlement contract, or any agreement the effect of which is to sell or acquire the policy or a beneficial interest in the policy, entered into within the four-year period commencing with the date the policy is issued creates a rebuttable presumption of STOLI practices if either of the following circumstances are present:

(1) there was an agreement or understanding, before issuance of the policy, between the insured, policyowner, or owner of a beneficial interest in the policy, and another person to guarantee any liability or

to purchase, or stand ready to purchase, the policy or an interest in the policy, including through an assumption or forgiveness of a loan; or

(2) both of the following are present:

(i) all or a portion of the policy premiums were funded by means other than by the insured's personal assets or assets provided by a person who is closely related to the insured by blood or law or who has a lawful and substantial economic interest in the continued life of the insured. For purposes of this provision, funds from a premium finance loan are considered assets of the insured or that person only if the insured or that person is contractually obligated to repay the full amount of the loan and to pledge personal assets, other than the policy itself, for loan amounts exceeding the policy's cash value; and

(ii) the insured underwent a life expectancy evaluation within the 18-month time period immediately prior to the issuance of the policy and, during the same time period, the results of the life expectancy evaluation were shared with or used by any person for the purpose of determining the actual or potential value of the policy in the secondary market.

Subd. 2. **Not applicable in criminal proceedings.** The rebuttable presumption created in this section does not apply in any criminal proceeding.

History: *2009 c 52 s 6*

60A.0787 PROCESSING CHANGE OF OWNERSHIP OR BENEFICIARY REQUESTS.

Subdivision 1. **Obligation to process change of ownership or beneficiary requests.** Upon receipt of a properly completed request for change of ownership or beneficiary of a policy and, if applicable, the completed questionnaire described in this section, the insurer shall respond in writing within 30 calendar days with written acknowledgment confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary and shall not otherwise interfere with any permitted settlement contract entered into in this state.

Subd. 2. **Written questionnaire.** If the insurer receives a request for change of ownership or beneficiary within the four-year period commencing with the date the policy is issued, the insurer may require, as a condition of effecting the requested change, that the policyowner complete and return a written questionnaire designed to determine whether the change request relates to or is made in accordance with a settlement contract and if so, whether the circumstances described in section 60A.0785 are present. The questionnaire shall be in a form approved by the commissioner and shall include, but not be limited to, the following:

(1) the definition of settlement contract;

(2) an inquiry regarding whether the request for change of ownership or beneficiary relates to or is made in accordance with a settlement contract;

(3) if the answer to clause (2) is "yes," then an inquiry regarding whether the circumstances described in section 60A.0785 are present;

(4) a disclosure that presenting false material information, or concealing material information, in connection with the questionnaire is defined under the laws of this state as a fraudulent act; and

(5) a signed certification by the policyowner that the answers and information provided in and pursuant to the questionnaire are true and complete to the best of the policyowner's knowledge and belief.

Subd. 3. **Other inquiries.** Nothing in this section should be interpreted to limit an insurer's ability to make other inquiries to detect STOLI practices.

Subd. 4. **Fraternal benefit societies.** Nothing in sections 60A.078 to 60A.0789 shall prohibit a fraternal benefit society regulated under chapter 64B from enforcing the terms of its bylaws or rules regarding permitted beneficiaries and owners.

History: *2009 c 52 s 7*

60A.0788 FRAUDULENT ACTS.

Subdivision 1. **Fraudulent acts.** A person who commits a fraudulent act as defined in this section commits insurance fraud and may be sentenced under section 609.611, subdivision 3.

Subd. 2. **List of fraudulent acts.** All of the following acts are fraudulent when committed by a person who, with intent to defraud and for the purpose of depriving another of property or for pecuniary gain, commits, or permits any of its employees or its agents to commit them:

(1) failing to disclose to the insurer where the insurer has requested such disclosure that the prospective insured has undergone a life expectancy evaluation;

(2) misrepresenting a person's state of residence or facilitating the change of the state in which a person resides for the express purpose of evading or avoiding the provisions of sections 60A.078 to 60A.0789;

(3) presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to an insurer any false material information, or concealing any material information, as part of, in support of, or concerning a fact material to one or more of the following:

(i) a questionnaire as provided for under section 60A.0787; or

(ii) any other documents or communications, whether written or verbal, which are intended to detect STOLI practices or demonstrate compliance with sections 60A.078 to 60A.0789;

(4) encouraging the insured, policyowner, or owner of a beneficial interest in the policy to falsely state that the circumstances described in section 60A.0785 are not present or aiding in the preparation or execution of documents designed to create the false impression that those circumstances are not present; and

(5) failing to request or to provide the broker certification required by section 60A.0785, subdivision 2, or falsely certifying that the life expectancy evaluation in section 60A.0785, subdivision 2, was not shared with any other person prior to the issuance of the policy for the purpose of determining the actual or potential value of the policy in the secondary market.

History: *2009 c 52 s 8*

60A.0789 REMEDIES.

Subdivision 1. **Actions to recover death benefits.** (a) If the beneficiary, assignee, or other payee receives the death benefits under a life insurance policy initiated by STOLI practices or a policy procured or effected in violation of section 60A.0783 or section 60A.0785, the personal representative of the insured's estate or other lawfully acting agent may maintain an action to recover such benefits from the person receiving them.

(b) Where a person receives the death benefit as a result of a nonwillful violation of sections 60A.078 to 60A.0789, the court may limit the recovery to unjust enrichment, calculated as the benefits received plus

interest from the date of receipt, less premiums paid under the policy by the recipient and any consideration paid by the recipient to the insured in connection with the policy.

(c) Where a person receives the death benefits as the result of a willful violation of sections 60A.078 to 60A.0789, the court may, in addition to actual damages, order the defendant or defendants to pay exemplary damages in an amount up to two times the death benefits. A pattern of violations of sections 60A.078 to 60A.0789 and conduct involving one or more fraudulent acts are evidence of willfulness. The exemplary damages shall be paid to one or more governmental agencies charged with combating consumer fraud, including the Department of Commerce.

(d) The court may award reasonable attorney fees, together with costs and disbursements, to any party that recovers damages in any action brought under this subdivision.

(e) An action under this subdivision must be brought within two years after the death of the insured.

Subd. 2. **Enforceability of contracts.** Any contract, agreement, arrangement, or transaction prohibited under sections 60A.078 to 60A.0789 is voidable.

Subd. 3. **Declaratory judgment action.** If, prior to payment of death benefits, the insurer believes the policy was initiated by STOLI practices, the insurer may bring a declaratory judgment action seeking a court order declaring the policy void.

Subd. 4. **Effect on other law.** Sections 60A.078 to 60A.0789 shall not:

(1) preempt or limit other civil remedies, including, but not limited to, declaratory judgments, injunctive relief, and interpleaders;

(2) preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(3) limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit or the attorney general to investigate and examine possible violations of law and to take appropriate actions against wrongdoers; or

(4) limit the power of this state to punish a person for conduct that constitutes a crime under other laws of this state.

History: *2009 c 52 s 9; 2014 c 198 art 4 s 3*

CONTRACTS

60A.08 CONTRACTS OF INSURANCE.

Subdivision 1. **Policy to contain entire contract.** A statement in full of the conditions of insurance shall be incorporated in or attached to every policy, and neither the application of the insured nor the bylaws of the company shall be considered as a warranty or a part of the contract, except in so far as they are so incorporated or attached.

Subd. 2. **Corporate name; origin and financial statements.** Every company, domestic or foreign, shall conduct its business, display all signs and advertisements, and issue all policies, circulars, and other documents and publications in this state, in its own corporate name, and every foreign company shall state conspicuously upon a sign at each agency the state or country of its organization. When a company publishes its assets, it shall in the same connection, and with equal conspicuousness, publish its liabilities, computed

on the basis allowed for its annual statements; and any publication purporting to show its capital shall state only the amount thereof which has been actually paid in cash.

Subd. 3. **Renewal; new policy.** Any insurance policy terminating by its provisions at a specified expiration date or limited as to term by any statute and not otherwise renewable may be renewed or extended at the option of the insurer, at the premium rate then required therefor, for a specific additional period or periods by a certificate, and without requiring the issuance of a new policy. The insurer must also post the current policy form on its website, or must inform the policyholder annually in writing that a copy of the current policy form is available on request.

Subd. 4. **Contracts; application of Minnesota law; prohibitions.** All contracts of insurance on property, lives, or interests in this state, shall be deemed to be made in this state.

It shall be unlawful for any person, firm, or corporation to solicit or make, or aid in soliciting or making, any contract of insurance not authorized by the laws of this state.

Subd. 5. **Signatures required.** All insurance policies shall be signed by the secretary or an assistant secretary, and by the president or vice-president, or in their absence, by two directors of the insurer. The signatures may be facsimile signatures.

Subd. 6. **Bankruptcy, insolvency, or dissolution clause.** Every bond or policy of insurance issued in this state insuring against either actual loss suffered by the insured, and imposed by law for damages on account of personal injury, death, or injury to property caused by accident, or legal liability imposed upon the insured by reason of such injuries or death, shall, notwithstanding anything in the policy to the contrary, be deemed to contain the following condition:

The bankruptcy, insolvency, or dissolution of the insured shall not relieve the insurer of any of its obligations under this policy, and in case an execution against the insured on a final judgment is returned unsatisfied, then such judgment creditor shall have a right of action on this policy against the company to the same extent that the insured would have, had the insured paid the final judgment.

Subd. 7. **Unsatisfied judgment.** When a judgment has been rendered by any court in this state against any company holding the commissioner's certificate, and an execution issued thereon has been returned unsatisfied, in whole or in part, and a certified transcript of the docket entry and the court administrator's certificate of those facts is filed with the commissioner, the commissioner shall forthwith revoke its certificate and give one week's published notice thereof. No new certificate shall issue until such judgment has been fully satisfied and proof thereof filed with the commissioner, and the expenses and fees incurred are paid. During this revocation neither the company, nor any of its officers or agents, shall issue any new policy, take any risk, or transact any business, except such as is absolutely necessary in closing up its affairs in this state.

Subd. 8. **Policies on which premiums are determined by audits.** Any insurance company licensed to do business in this state which issues policies of insurance in this state upon which the premium is determined by means of an audit shall within 60 days from the date of the expiration of any insurance policy so issued request from the insured a statement of the facts and figures necessary to determine the premium thereon. The insured shall furnish such statement of facts and figures within 60 days of the date of the request. Upon failure of the insured to comply within the time specified, then the provisions of this subdivision shall not apply as to such insured. Within 12 months from the date of the expiration of the policy, or within such longer time as the commissioner of commerce may for cause shown direct, the insurer unless it elects to accept the insured's statement shall make a final audit. Failure to make such final audit within the time herein provided shall constitute a waiver of the insurer's right to make such audit and an election to accept the

statement furnished by the insured as a basis for determining the premium on such policy. In the event an audit discloses that the insured submitted to the insurer a fraudulent statement of facts and figures, then the insured shall be liable for three times the normal premium. This subdivision shall not apply to policies issued covering workers' compensation.

Subd. 9. **Misrepresentation by applicant.** No oral or written misrepresentation made by the assured, or in the assured's behalf, in the negotiation of insurance, shall be deemed material, or defeat or avoid the policy, or prevent its attaching, unless made with intent to deceive and defraud, or unless the matter misrepresented increases the risk of loss.

This subdivision shall not apply to life insurance or accident and health insurance.

Subd. 10. **Legal expense insurance.** No contract of insurance written pursuant to the authority to transact the kind of business enumerated in section 60A.06, subdivision 1, clause (15), shall include any provision interfering with the attorney-client relationship.

Subd. 11. **Directors' and officers' liability policies.** No misrepresentation or omission made in an application or negotiation for any policy providing directors and officers liability coverage for directors or officers of a corporation shall defeat or avoid coverage or prevent the policy from attaching for a director or officer unless the director or officer has signed the application and has actual knowledge of the facts misrepresented or omitted. The application shall be attached to and incorporated into the contract. This subdivision applies with respect to all policies governed by this chapter or issued or renewed in this state.

Subd. 12. **Rented vehicles.** All commercial automobile liability policies must provide coverage for rented vehicles as required in chapter 65B.

This coverage can be excess over any and all specific motor vehicle coverage that is applicable.

Subd. 13. **Reduction of limits by costs of defense prohibited.** (a) No insurer shall issue or renew a policy of liability insurance in this state that reduces the limits of liability stated in the policy by the costs of legal defense.

(b) This subdivision does not apply to:

(1) professional liability insurance with annual aggregate limits of liability of at least $100,000, including directors' and officers' and errors and omissions liability insurance;

(2) environmental impairment liability insurance;

(3) insurance policies issued to large commercial risks; or

(4) coverages that the commissioner determines to be appropriate which will be published in the manner prescribed for surplus lines insurance in section 60A.201, subdivision 4.

(c) For purposes of this subdivision, "large commercial risks" means an insured whose gross annual revenues in the fiscal year preceding issuance of the policy were at least $10,000,000.

Subd. 14. **Agreement to rescind policy or release bad faith claim.** (a) If the insurer has knowledge of any claims against the insured that would remain unsatisfied due to the financial condition of the insured, the insurer and the insured may not agree to:

(1) rescind the policy; or

(2) directly or indirectly transfer to, or release to, the insurer the insured's claim or potential claim against the insurer based upon the insurer's refusal to settle a claim against the insured.

(b) Before entering into an agreement described in paragraph (a), an insurer must make a good faith effort to ascertain: (1) the existence and identity of all claims against the policy; and (2) the financial condition of the insured.

(c) The insured must provide reasonable financial information upon request of the insurer.

(d) An agreement made in violation of this section is void and unenforceable.

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

(b) All forms, rates, and related information filed with the commissioner under section 62A.02 shall be nonpublic data until the filing becomes effective.

(c) All forms, rates, and related information filed with the commissioner under section 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

(d) All forms, rates, and related information filed with the commissioner under section 70A.06 shall be nonpublic data until the filing becomes effective.

(e) All forms, rates, and related information filed with the commissioner under section 79.56 shall be nonpublic data until the filing becomes effective.

(f) All forms, rates, and related information filed with the commissioner under section 65A.298 are nonpublic data until the filing becomes effective.

(g) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review under section 2794 of the Public Health Services Act and any amendments to, or regulations, or guidance issued under the act that are filed with the commissioner on or after September 1, 2011, the commissioner:

(1) may acknowledge receipt of the information;

(2) may acknowledge that the corresponding rate filing is pending review;

(3) must provide public access from the Department of Commerce's website to parts I and II of the Preliminary Justifications of the rate increases subject to review; and

(4) must provide notice to the public on the Department of Commerce's website of the review of the proposed rate, which must include a statement that the public has 30 calendar days to submit written comments to the commissioner on the rate filing subject to review.

(h) Notwithstanding paragraphs (b) and (c), for all proposed premium rates filed with the commissioner for individual health plans, as defined in section 62A.011, subdivision 4, and small group health plans, as defined in section 62K.03, subdivision 12, the commissioner must provide public access on the Department of Commerce's website to compiled data of the proposed changes to rates, separated by health plan and geographic rating area, within ten business days after the deadline by which health carriers, as defined in section 62A.011, subdivision 2, must submit proposed rates to the commissioner for approval.

Subd. 16. **Foreign language policies and advertising.** (a) Insurance policies, endorsements, riders, and any explanatory or advertising material may be issued in a language other than English. In the event of a dispute or complaint regarding the insurance or advertising material, the English language version of the

insurance coverage shall control the resolution of the dispute or complaint. Any insurance policy, endorsement, rider, or advertising material required by law to be filed with the commissioner that is prepared in a language other than English must be accompanied by an English language translation certifying that the English version is substantively identical to the filed version.

(b) This subdivision does not limit the application of chapter 72A.

History: *1967 c 395 art 1 s 8; 1973 c 634 s 5; 1975 c 359 s 23; 1977 c 195 s 1; 1979 c 115 s 1; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1985 c 251 s 1; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1988 c 611 s 1; 1989 c 260 s 2,3; 1991 c 131 s 1; 1996 c 446 art 1 s 1; 2001 c 215 s 2; 2005 c 74 s 1; 2006 c 202 s 2; 2009 c 178 art 1 s 5; 2013 c 84 art 1 s 3; 2013 c 130 s 1; 2017 c 2 art 2 s 1; 2023 c 57 art 2 s 1*

AIRCRAFT INSURANCE

60A.081 AIRCRAFT INSURANCE.

Subdivision 1. **Compliance exclusions prohibited; exception.** (a) No policy of insurance issued or delivered in this state covering any loss, damage, expense, or liability arising out of the ownership, maintenance, or use of an aircraft, shall exclude or deny coverage because the aircraft is operated in violation of federal or civil air regulations, state law or rules, or local ordinances. This section does not prohibit the use of specific exclusions or conditions in the policy which relate to:

(1) certification of an aircraft in a stated category by the federal aviation administration;

(2) certification of a pilot in a stated category by the federal aviation administration;

(3) establishing requirements for pilot experience; or

(4) establishing limitations on the use of the aircraft.

(b) An insured's action or failure to act is not a basis for denial of a claim, unless the insured's action or failure to act had a direct causal connection to the loss upon which the claim is based. For purposes of this paragraph, "denial of a claim" includes refusal to pay a claim due to a retroactive termination of the policy on the basis of the insured's action or failure to act.

Subd. 2. **Liability exclusions prohibited; exception.** Except as provided in subdivision 1, no policy of insurance issued or delivered in this state covering an aircraft equipped with passenger seats and covering liability hazards shall be issued excluding coverage for injury to or death of passengers or nonpassengers except as to a policy of insurance exclusively covering "commercial operations" as defined by section 360.013, subdivision 45, where the pilot of the aircraft has in force a separate policy of insurance providing for coverage on the aircraft as required by section 360.59, subdivision 10.

Subd. 3. **Nonapplication of section.** The provisions of this section shall not apply as to any policy issued covering aircraft being used in air commerce as defined by section 360.511, subdivision 4.

History: *1969 c 629 s 1; 1976 c 241 s 1; 1985 c 248 s 70; 2008 c 182 s 1*

BREACH OF POLICY

60A.0811 BREACH OF INSURANCE POLICY; RECOVERY OF INTEREST.

Subdivision 1. **Definitions.** For purposes of this section:

(1) "insurance policy" means a commercial or professional insurance policy or contract other than:

(i) a workers' compensation insurance policy or contract;

(ii) a health insurance policy or contract issued, executed, renewed, maintained, or delivered in this state by a health carrier as defined in section 62A.011, subdivision 2;

(iii) a life insurance or disability insurance policy or contract; or

(iv) a policy or contract issued by a township mutual fire insurance company operating under chapter 65A;

(2) "insured" means any named insured, additional insured, or insured under an insurance policy; and

(3) "insurer" means an insurer:

(i) incorporated or organized in this state; or

(ii) admitted, authorized, or licensed to do business or doing business in this state but not incorporated or organized in this state. Insurer does not include the joint underwriting association operating under chapter 62F or 62I; or a township mutual fire insurance company operating under chapter 65A.

Subd. 2. **Interest.** (a) An insured who prevails in any claim against an insurer based on the insurer's breach or repudiation of, or failure to fulfill, a duty to provide services or make payments is entitled to recover ten percent per annum interest on monetary amounts due under the insurance policy, calculated from the date the request for payment of those benefits was made to the insurer.

(b) Punitive damages or damages for nonmonetary losses are not recoverable under this section.

Subd. 3. **Application.** This section applies to a court action or arbitration proceeding, including an action seeking declaratory judgment.

History: *2009 c 148 s 1; 2012 c 187 art 1 s 10*

60A.0812 PROPERTY AND CASUALTY POLICY EXCLUSIONS.

Subdivision 1. **Short title.** This section may be cited as the "Family Protection Act."

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Boat" means a motorized or nonmotorized vessel that floats and is used for personal, noncommercial use on waters in Minnesota.

(c) "Boat insurance policy" means an insurance policy that provides liability coverage for bodily injury resulting from the ownership, maintenance, or use of a boat, although the policy may also provide for property insurance coverage for the boat for noncommercial use.

(d) "Insured" means an insured under a policy specified in subdivision 3, clauses (1) to (4), including the named insured and the following persons not identified by name as an insured while residing in the same household with the named insured:

(1) a spouse of a named insured;

(2) a relative of a named insured; or

(3) a minor in the custody of a named insured, spouse of a named insured, or of a relative residing in the same household with a named insured.

For purposes of this section, a person resides in or is a member of the same household with the named insured if the person's home is usually in the same family unit, even if the person is temporarily living elsewhere.

(e) "Permitted exclusion" means an exclusion of or limitation on liability for damages for bodily injury resulting from fraud, intentional conduct, criminal conduct that intentionally causes an injury, and other exclusions permitted by law, including a permitted exclusion contained in a boat insurance policy issued in this state pursuant to subdivision 6.

(f) "Prohibited exclusion" means an exclusion of or limitation on liability for damages for bodily injury because the injured person is:

(1) an insured other than a named insured;

(2) a resident or member of the insured's household; or

(3) related to the insured by blood or marriage.

Subd. 3. **Prohibited exclusions.** A prohibited exclusion contained in a plan or policy identified in clauses (1) to (4) is against public policy and is void. The following insurance coverage issued in this state must not contain a prohibited exclusion, unless expressly provided otherwise under this section:

(1) a plan of reparation security, as defined under section 65B.43;

(2) a boat insurance policy;

(3) a personal excess liability policy; and

(4) a personal umbrella policy.

Subd. 4. **Permitted exclusions.** An insurance policy listed in this section may contain a permitted exclusion for bodily injury to an insured.

Subd. 5. **Underlying coverage requirement.** An excess or umbrella policy may contain a requirement that coverage for family or household members under an excess or umbrella policy governed by this section is available only to the extent coverage is first available from an underlying policy that provides coverage for damages for bodily injury.

Subd. 6. **Election of coverage for boat insurance policies.** (a) An insurer issuing bodily injury liability coverage for a boat insurance policy under this section must notify a person at the time of sale of the person's rights under this section to decline coverage for insureds and be provided an updated quote reflecting the appropriate premium for the coverage provided.

(b) Named insureds must affirmatively make an election to decline coverage, in a form approved by the commissioner, after being informed that an updated quote will be provided. The election must be signed and dated, and is binding on all persons insured under the policy and to any renewal of the policy.

(c) An insurer offering an election of coverage under this subdivision must have the disclosure approved by the commissioner. The notice must be in 14-point bold type, in a conspicuous location of the notice document, and contain at least the following:

ELECTION TO DECLINE COVERAGE: YOU HAVE THE RIGHT TO DECLINE BODILY INJURY COVERAGE FOR INJURIES TO YOUR FAMILY AND HOUSEHOLD MEMBERS FOR WHICH YOU WOULD OTHERWISE BE ENTITLED TO UNDER MINNESOTA LAW. IF YOU ELECT TO DECLINE THIS COVERAGE, YOU WILL RECEIVE AN UPDATED PREMIUM QUOTE BASED ON THE COVERAGE YOU ARE ELECTING TO PURCHASE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FAMILY AND HOUSEHOLD MEMBERS WOULD NOT BE COVERED FOR BODILY INJURY IF YOU ELECT TO DECLINE COVERAGE.

Subd. 7. **No endorsement required.** An endorsement, rider, or contract amendment is not required for this section to be effective.

History: *2023 c 57 art 2 s 2*

GROUP POLICIES

60A.082 GROUP INSURANCE; BENEFITS CONTINUED IF INSURER CHANGED.

A person covered under group life, group accidental death and dismemberment, group disability income or group medical expense insurance, shall not be denied benefits to which the person is otherwise entitled solely because of a change in the insurance company writing the coverage or in the group contract applicable to the person. In the case of one or more carriers replacing or remaining in place after one or more plans have been discontinued, each carrier shall accept any person who was covered under the discontinued plan or plans without denial of benefits to which other persons in the group covered by that carrier are entitled. "Insurance company" shall include a service plan corporation under chapter 62C or 62D.

For purposes of satisfying any preexisting condition limitation, the insurance company shall credit the period of time the person was covered by the prior plan, if the person has maintained continuous coverage.

The commissioner shall promulgate rules to carry out this section. Nothing in this section shall preclude an employer, union or association from reducing the level of benefits under any group insurance policy or plan.

History: *1980 c 459 s 1; 1984 c 464 s 1; 1986 c 444; 1994 c 485 s 7*

60A.084 NOTIFICATION ON GROUP POLICIES.

An employer providing life or health benefits may not change benefits, limit coverage, or otherwise restrict participation until the certificate holder or enrollee has been notified of any changes, limitations, or restrictions. Notice in a format which meets the requirements of the United States Department of Labor is satisfactory for compliance with this section.

History: *1987 c 337 s 3; 2010 c 384 s 5*

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

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

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

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

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

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

(f) In the case of a group life, group accidental death and dismemberment, or group disability income policy, the insurer and group policyholder may agree that the group policyholder assumes responsibility for notifying all covered persons if a cancellation under paragraphs (a) and (c) occurs. As part of the agreement, the group policyholder must certify to the insurer that the notification required under this section has taken place. If the employer assumes responsibility for the notification, paragraphs (b), (d), and (e) do not apply.

History: *1992 c 564 art 4 s 3; 1994 c 485 s 8; 1995 c 258 s 2; 2026 c 124 art 1 s 33*

60A.086 RETROACTIVE TERMINATION OF COVERAGE UNDER GROUP POLICIES PROHIBITED.

Subdivision 1. **Applicability.** This section applies to:

(1) health plans as defined in section 62A.011, issued to groups;

(2) group accident and health insurance;

(3) group life insurance;

(4) group accidental death and dismemberment insurance; and

(5) group disability income insurance.

Subd. 2. **Requirement.** No plan of coverage described in subdivision 1 shall permit the issuer to retroactively cancel, retroactively rescind, or otherwise retroactively terminate the coverage of an employee, dependent, or other covered person under the group coverage, without the written consent of that employee, dependent, or other covered person. For purposes of this subdivision, "covered person" includes a person on continuation coverage or eligible for continuation coverage.

Subd. 3. **Nonapplicability.** (a) This section does not apply where the group policy or contract is lawfully terminated retroactively and not replaced with substantially similar coverage.

(b) This section does not apply where the employee, dependent, or other covered person committed fraud or misrepresentation with respect to eligibility under the terms of the group policy or contract or with respect to any other material fact, but retroactive termination without written consent must not be based upon the failure of the employee, dependent, or other covered person to meet the group sponsor's eligibility requirements, if the group sponsor requested the issuer of the coverage to include the person as a covered person.

(c) This section does not apply where the issuer of coverage described in subdivision 1 retroactively terminates coverage of an employee, dependent, or other covered person solely because the group sponsor did not notify the issuer of the coverage in advance of the employee's voluntary or involuntary termination from employment, provided that the retroactive termination of coverage is effective no earlier than the end of the day of termination from employment. This paragraph does not affect continuation rights under federal or state law and does not limit the effect of section 62Q.16.

History: *1996 c 304 s 1*

FINANCIAL REGULATION

60A.09 LIMITS OF RISK; REINSURANCE.

Subdivision 1. **Maximum risk.** No company other than a company authorized to transact the kind of business specified in section 60A.06, subdivision 1, clause (7), shall insure or reinsure in a single risk a larger sum than one-tenth of its net assets, and no company authorized to transact the kind of business specified in section 60A.06, subdivision 1, clause (7), shall insure or reinsure in a single risk a larger sum than two-thirds of its net assets; provided, that in the case of a company with net assets of more than $50,000, any portion of the risk which has been reinsured, as authorized by the laws of this state, shall be deducted before determining the limitation of risk prescribed by this subdivision; and, provided, that a mutual insurance company organized under clause (2)(a) of section 66A.08, subdivision 2, may insure in a single risk, consisting of a creamery or a cheese factory, a sum equal to one percent of its insurance in force.

Subd. 2. **Reinsurance to be reported by companies other than life.** If any company, other than life, shall, directly or indirectly, effect the reinsurance of any risk taken by it, or any part thereof, it shall make a sworn report thereof to the commissioner, at the time of filing its annual statement, or at such other time as the commissioner may request.

Subd. 3. **Penalty for violation.** Every company effecting any reinsurance in violation of the foregoing provisions, and every agent effecting or negotiating the same, shall severally be guilty of a misdemeanor.

Subd. 4. [Repealed, 1991 c 325 art 1 s 16]

Subd. 4a. **Assumption transactions regulated.** No company, whether domestic, foreign, or alien, shall perform an assumption transaction, including an assumption reinsurance agreement, with respect to a policy issued to a Minnesota resident, unless:

(1) the assumption agreement has been filed with the commissioner;

(2) the assumption agreement specifically provides that the original insurer remains liable to the insured in the event the assuming insurer is unable to fulfill its obligations or the original insurer acknowledges in writing to the commissioner that it remains liable to the insured in the event the assuming insurer is unable to fulfill its obligations;

(3) the proposed certificate of assumption to be provided to the policyholder has been filed with the commissioner for review and approval as provided in section 61A.02; and

(4) the proposed certificate of assumption contains, in boldface type, the following language:

"Policyholder: Please be advised that you retain all rights with respect to your policy against your original insurer in the event the assuming insurer is unable to fulfill its obligations. In such event, your original insurer remains liable to you notwithstanding the terms of its assumption agreement."

With respect to residents of Minnesota, the notice to policyholders shall also include a statement as to the effect on guaranty fund coverage, if any, that will result from the transfer.

Clauses (2) and (4) above do not apply if the policyholder consents in a signed writing to a release of the original insurer from liability and to a waiver of the protections provided in clauses (2) and (4) after being informed in writing by the insurer of the circumstances relating to and the effect of the assumption, provided that the consent form signed by the policyholder has been filed with and approved by the commissioner.

If a company is deemed by the commissioner to be in a hazardous condition or is under a court ordered supervision, rehabilitation, liquidation, conservation or receivership, and the transfer of policies is in the best interest of the policyholders, as determined by the commissioner, a transfer may be effected notwithstanding the provisions in this subdivision by using a different form of consent by policyholders. This may include a form of implied consent and adequate notification to the policyholder of the circumstances requiring the transfer as approved by the commissioner. This paragraph does not apply when a policy is transferred to the Minnesota Life and Health Guaranty Association or to the Minnesota Insurance Guaranty Association.

Subd. 5. **Reinsurance.** (1) **Definitions.** For the purposes of this subdivision, the word "insurer" shall be deemed to include the word "reinsurer," and the words "issue policies of insurance" shall be deemed to include the words "make contracts of reinsurance."

(2) **Reinsurance of more than 50 percent of insurance liabilities.** Any contract of reinsurance whereby an insurer cedes more than 50 percent of the total of its outstanding insurance liabilities shall, if such insurer is incorporated by or, if an insurer of a foreign country, has its principal office in this state, be subject to the approval, in writing, by the commissioner.

(3) **Aircraft risks.** An insurer authorized to transact the business specified in section 60A.06, subdivision 1, clauses (4) and (5)(a), may through reinsurance assume any risk arising from, related to, or incident to the manufacture, ownership, or operation of aircraft and may retrocede any portion thereof; provided, however, that no insurer may undertake any such reinsurance business without the prior approval of the commissioner and such reinsurance business shall be subject to any regulations which may be promulgated by the commissioner. Any such reinsurance business may be provided through pooling arrangements with other insurers for purposes of spreading the insurance risk.

Subd. 6. **Bulk reinsurance, regulation.** (1) No bulk reinsurance agreement entered into by an insurance company, other than life insurance companies, having a capital and surplus or surplus of $5,000,000 or less, shall be used to reduce the liabilities or expense of the reinsured company until and unless the agreement has been filed with and approved by the commissioner. The commissioner will be deemed to have approved any agreement filed unless the commissioner notifies the insurance company of disapproval within 30 days or requests a reasonable extension of time within such 30 days.

(2) No filing shall be made pursuant to the foregoing clause (1) unless the reinsurance agreement be certified under oath by responsible officers of the reinsurer and the reinsured to contain the entire agreement between the parties to the reinsurance agreement.

Misrepresentations contained in the reinsurance agreement or in any information supplied to the commissioner relative thereto shall be subject to the penalties for perjury.

(3) It shall be unlawful for any reinsurance agreement to contain any provisions which have the effect of nullifying the liability which the reinsurer purports to assume.

(4) For the purposes of this subdivision, "bulk reinsurance" shall mean any quota share, surplus aid or portfolio reinsurance agreement which, of itself or in combination with other similar agreements, assumes 20 percent or more of the liability of the reinsured company.

(5) Every company effecting any bulk reinsurance in violation of the foregoing provisions, and every person effecting or negotiating the same, shall severally be guilty of a misdemeanor.

(6) Reinsurance agreements filed hereunder shall not be matters of public record, but this shall not be construed to limit the disclosure of reinsurance agreements in examination reports.

Subd. 7. **Title insurance risks.** For a company authorized to transact a kind of business specified in section 60A.06, subdivision 1, clause (7), the term "single risk" as used in this section shall mean the insured amount of any policy or contract unless two or more policies or contracts are simultaneously issued on different estates in identical real property, in which event, it means the sum of the insured amounts of all such policies or contracts; provided, any policy or contract that insures a mortgage interest that is excepted in a fee or leasehold policy or contract, and which does not exceed the insured amount of the fee or leasehold policy or contract, shall be excluded in computing the amount of a single risk.

History: *1967 c 395 art 1 s 9; Ex1967 c 10 s 1-6; 1973 c 391 s 1; 1978 c 465 s 3; 1980 c 505 s 1,2; 1985 c 248 s 70; 1986 c 444; 1989 c 260 s 4; 1991 c 325 art 1 s 10; art 20 s 1; 1996 c 446 art 1 s 2; 2002 c 336 s 2*

60A.091 DEFINITION; QUALIFIED UNITED STATES FINANCIAL INSTITUTION.

For purposes of sections 60A.092 and 60A.093, "qualified United States financial institution" means an institution that:

(1) is organized or, in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state;

(2) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies; and

(3) is a member of the Federal Deposit Insurance Corporation or the National Credit Union Administration, or is insured by an approved credit union share guaranty corporation.

History: *1991 c 325 art 1 s 11; 2026 c 56 s 16*

60A.092 REINSURANCE CREDIT ALLOWED A DOMESTIC CEDING INSURER.

Subdivision 1. **Credit allowed.** Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurance is ceded to an assuming insurer which meets the requirements specified under this section.

Subd. 2. **Licensed assuming insurer.** Reinsurance is ceded to an assuming insurer if the assuming insurer is licensed to transact insurance or reinsurance in this state. For purposes of reinsuring any health risk, an insurer is defined under section 62A.63.

Subd. 3. **Accredited assuming insurer.** Reinsurance is ceded to an assuming insurer if the assuming insurer is accredited by the commissioner as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer must:

(1) file with the commissioner evidence of its submission to this state's jurisdiction;

(2) submit to this state's authority to examine its books and records;

(3) be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state;

(4) file annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile, a copy of its most recent audited financial statement, and a filing fee of $225; and

(5)(i) demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer meets this requirement at the time of its application if it maintains a surplus as regards to policyholders in an amount not less than $20,000,000 and its accreditation has not been denied by the commissioner within 90 days after submission of its application; or

(ii) maintains a surplus as regards policyholders in an amount not less than $50,000,000 for long-tail casualty reinsurers. For purposes of this section, "long-tail casualty reinsurance" means insurance for medical or legal malpractice, pollution liability, directors and officers liability, and products liability. The commissioner may determine that an assuming insurer that maintains a surplus as regards policyholders in an amount not less than $20,000,000 is accredited as a reinsurer if there is no detriment to policyholders and the interest of the public, and to not allow accrediting would be a hardship or detriment to the reinsurer. The commissioner shall report to the legislature on any determination to allow accrediting to a long-term casualty reinsurer maintaining a surplus in an amount less than $50,000,000.

Clause (5) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

Subd. 4. **Similar state standards.** Reinsurance is ceded to an assuming insurer if the assuming insurer is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this chapter and the assuming insurer or United States branch of an alien assuming insurer (1) maintains a surplus as regards policyholders in an amount not less than $20,000,000 or maintains a surplus as regards policyholders in an amount not less than $50,000,000 for long-tail casualty reinsurers as provided under subdivision 3, clause (5), and (2) submits to the authority of this state to examine its books and records.

Clause (1) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

Subd. 5. **Trust fund maintained.** The reinsurance is ceded to an assuming insurer if the assuming insurer maintains a trust fund in a qualified United States financial institution for the payment of the valid claims, as determined by the commissioner for the purpose of determining the sufficiency of the trust fund, of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund.

Subd. 6. **Single assuming insurer; trust fund requirements.** (a) In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, a trusteed surplus of not less than $20,000,000 or an additional amount as the commissioner considers necessary, except as provided in paragraph (b). The

assuming insurer shall maintain its surplus as regards policyholders in an amount not less than $50,000,000 for long-tail casualty reinsurers as provided under subdivision 3, clause (5).

(b) After the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three years, the commissioner may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

Subd. 7. **Underwriters group; trust fund requirements.** In the case of a group including incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States. The group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of United States ceding insurers of any member of the group. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and must be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. The group shall make available to the commissioner an annual certification by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter.

Subd. 8. **Incorporated insurers group; trust fund requirements.** A group of incorporated insurers under common administration must:

(1) comply with the filing requirements specified in subdivision 7;

(2) be under the supervision of the Department for International Trade of the United Kingdom;

(3) submit to this state's authority to examine its books and records;

(4) bear the expense of the examination;

(5) maintain an aggregate policyholders' surplus of $10,000,000,000;

(6) maintain the trust in an amount equal to the group's several liabilities attributable to business written in the United States; and

(7) maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group.

Each member of the group shall make available to the commissioner an annual certification by the member's domiciliary regulator and its independent accountant of the member's solvency.

Subd. 9. **Trust fund general requirements.** (a) The trust must be established in a form approved by the commissioner of commerce. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination

as determined by the commissioner. The trust must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust.

(b) No later than February 28 of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

Subd. 10. **Certification of assuming insurers in qualifying jurisdictions.** (a) Reinsurance is ceded to an assuming insurer if the assuming insurer has been certified by the commissioner as a reinsurer in this state and secures its obligations according to this subdivision.

(b) To be eligible for certification, the assuming insurer must:

(1) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner under paragraph (d);

(2) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner;

(3) maintain financial strength ratings from two or more rating agencies acceptable to the commissioner;

(4) agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state, and agree to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(5) agree to meet filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis; and

(6) satisfy any other requirements for certification as determined by the commissioner.

(c) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. In addition to satisfying the requirements of paragraph (b), an association must:

(1) satisfy its minimum capital and surplus requirements through the capital and surplus equivalents net of liabilities of the association and its members, which includes a joint central fund that may be applied to an unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection;

(2) ensure the incorporated members of the association are not engaged in a business other than underwriting as a member of the association and are subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(3) within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member, or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(d) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be considered by the commissioner to become a certified reinsurer.

(e) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner determines that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered at the discretion of the commissioner.

(f) A list of qualified jurisdictions must be published through the National Association of Insurance Commissioners (NAIC) committee process. The commissioner shall consider the list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification.

(g) United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program must be recognized as qualified jurisdictions.

(h) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

(i) The commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies acceptable to the commissioner. The commissioner shall publish a list of all certified reinsurers and their ratings.

(j) A certified reinsurer covered by paragraphs (k) to (o) shall secure obligations assumed from United States ceding insurers at a level consistent with its rating determined under section 60A.0921, subdivision 1, paragraph (d).

(k) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer must maintain security in a form acceptable to the commissioner and consistent with section 60A.093, or in a multibeneficiary trust according to subdivisions 5 to 9, except as otherwise provided in this subdivision.

(l) If a certified reinsurer maintains a trust to fully secure its obligations subject to subdivisions 5 to 9, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subdivision or comparable laws of other United States jurisdictions and for its obligations subject to subdivisions 5 to 9. It is a condition to the grant of certification under this subdivision that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner, to fund, upon termination of a trust account, any deficiency of any other trust account out of the remaining surplus of each trust.

(m) The minimum trusteed surplus requirements provided in subdivisions 5 to 9 are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subdivision, except that the trust shall maintain a minimum trusteed surplus of $10,000,000.

(n) With respect to obligations incurred by a certified reinsurer under this subdivision, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency. The commissioner may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(o) For purposes of this subdivision, a certified reinsurer whose certification has been terminated for any reason must be treated as a certified reinsurer required to secure 100 percent of its obligations. As used in this subdivision, "terminated" means revocation, suspension, voluntary surrender, or inactive status. If the commissioner continues to assign a higher rating as permitted by other provisions of this section, the requirements of this paragraph do not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(p) If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the commissioner may defer to that jurisdiction's certification and the rating assigned by that jurisdiction. The assuming insurer is considered to be a certified reinsurer in this state.

(q) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with this subdivision, and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(r) Credit for reinsurance under this section applies only to a reinsurance contract entered into or renewed on or after the effective date of the certification of the assuming insurer.

Subd. 10a. **Other jurisdictions.** The reinsurance is ceded and credit allowed to an assuming insurer not meeting the requirements of subdivision 2, 3, 4, 5, 10, or 10b, but only with respect to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

Subd. 10b. **Credit allowed; reciprocal jurisdiction.** (a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the following conditions:

(1) the assuming insurer must have its head office in or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. A "reciprocal jurisdiction" means a jurisdiction that is:

(i) a non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subdivision, a "covered agreement" means an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, United States Code, title 31, sections 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in Minnesota or for allowing the ceding insurer to recognize credit for reinsurance;

(ii) a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners (NAIC) financial standards and accreditation program; or

(iii) a qualified jurisdiction, as determined by the commissioner, which is not otherwise described in item (i) or (ii) and which meets the following additional requirements, consistent with the terms and conditions of in-force covered agreements:

(A) provides that an insurer which has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a United States-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;

(B) does not require a United States-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the

non-United States jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

(C) recognizes the United States state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; and

(D) provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC;

(2) the assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, on at least an annual basis as of the preceding December 31 or on the date otherwise statutorily reported to the reciprocal jurisdiction, in the following amounts:

(i) no less than $250,000,000; or

(ii) if the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

(A) minimum capital and surplus equivalents, net of liabilities, or own funds of the equivalent of at least $250,000,000; and

(B) a central fund containing a balance of the equivalent of at least $250,000,000;

(3) the assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, as follows:

(i) if the assuming insurer has its head office or is domiciled in a reciprocal jurisdiction defined in clause (1), item (i), the ratio specified in the applicable covered agreement;

(ii) if the assuming insurer is domiciled in a reciprocal jurisdiction defined in clause (1), item (ii), a risk-based capital ratio of 300 percent of the authorized control level, calculated in accordance with the formula developed by the NAIC; or

(iii) if the assuming insurer is domiciled in a Reciprocal Jurisdiction defined in clause (1), item (iii), after consultation with the reciprocal jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency;

(4) the assuming insurer must agree and provide adequate assurance in the form of a properly executed Form RJ-1 of its agreement to the following:

(i) the assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in clause (2) or (3), or if any regulatory action is taken against the assuming insurer for serious noncompliance with applicable law;

(ii) the assuming insurer must consent in writing to the jurisdiction of the courts of Minnesota and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this subdivision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(iii) the assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(iv) each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate;

(v) the assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to 100 percent of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. The security shall be in a form consistent with sections 60A.092, subdivision 10, 60A.093, 60A.096, and 60A.097. For purposes of this section, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction; and

(vi) the assuming insurer must agree in writing to meet the applicable information filing requirements set forth in clause (5);

(5) the assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the following documentation to the commissioner:

(i) for the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;

(ii) for the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;

(iii) prior to entry into the reinsurance agreement and not more than semiannually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and

(iv) prior to entry into the reinsurance agreement and not more than semiannually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming

insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in clause (6);

(6) the assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

(i) more than 15 percent of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner;

(ii) more than 15 percent of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a covered agreement; or

(iii) the aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a covered agreement;

(7) the assuming insurer's supervisory authority must confirm to the commissioner by December 31, 2021, and annually thereafter, or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in clauses (2) and (3); and

(8) nothing in this subdivision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(b) The commissioner shall timely create and publish a list of reciprocal jurisdictions. The commissioner's list shall include any reciprocal jurisdiction as defined under paragraph (a), clause (1), items (i) and (ii), and shall consider any other reciprocal jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions in accordance with criteria developed under rules issued by the commissioner. The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rules issued by the commissioner, except that the commissioner shall not remove from the list a reciprocal jurisdiction as defined under paragraph (a), clause (1), items (i) and (ii). Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to law.

(c) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subdivision and to which cessions shall be granted credit in accordance with this subdivision. The commissioner may add an assuming insurer to the list if an NAIC accredited jurisdiction has added the assuming insurer to a list of assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under paragraph (a), clause (4), and complies with any additional requirements that the commissioner may impose by rule, except to the extent that they conflict with an applicable covered agreement.

(i) If an NAIC-accredited jurisdiction has determined that the conditions set forth in paragraph (a), clause (2), have been met, the commissioner has the discretion to defer to that jurisdiction's determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this paragraph. The commissioner may accept financial documentation filed with another NAIC-accredited jurisdiction or with the NAIC in satisfaction of the requirements of paragraph (a), clause (2);

(ii) When requesting that the commissioner defer to another NAIC-accredited jurisdiction's determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the

commissioner may require. A state that has received such a request will notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

(d) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subdivision, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subdivision in accordance with procedures set forth in rule. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit, except to the extent that the assuming insurer's obligations under the contract are secured in accordance with this section. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of this section.

(e) Before denying statement credit or imposing a requirement to post security with respect to paragraph (d) or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall:

(1) communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in paragraph (a), clause (2);

(2) provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;

(3) after the expiration of 90 days or less, as set out in clause (2), if the commissioner determines that no or insufficient action was taken by the assuming insurer, the commissioner may impose any of the requirements as set out in this paragraph; and

(4) provide a written explanation to the assuming insurer of any of the requirements set out in this paragraph.

(f) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(g) Nothing in this subdivision limits or in any way alters the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in the reinsurance agreement, except as expressly prohibited by applicable law or rule.

(h) Credit may be taken under this subdivision only for reinsurance agreements entered into, amended, or renewed on or after January 1, 2022, and only with respect to losses incurred and reserves reported on or after the later of: (1) the date on which the assuming insurer has met all eligibility requirements pursuant to this subdivision; and (2) the effective date of the new reinsurance agreement, amendment, or renewal. This paragraph does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subdivision, as long as the reinsurance qualifies for credit under any other applicable provision of law. Nothing in this subdivision shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement, except as permitted by the terms of the

agreement. Nothing in this subdivision shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

Subd. 11. **Reinsurance agreement requirements.** (a) If the assuming insurer is not licensed, certified, or accredited to transact insurance or reinsurance in this state, the credit authorized under subdivisions 4 to 9 shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(1) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, comply with all requirements necessary to give the court jurisdiction, and abide by the final decision of the court or of any appellate court in the event of an appeal;

(2) to designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer; and

(3) that the credit risk for an intermediary is carried by the assuming insurer.

(b) Paragraph (a) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if an obligation to do so is created in the agreement.

(c) Credit will not be granted, nor an asset or a reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of subdivision 2, 3, 4, 5, 6, 7, or 10, unless the reinsurance contract provides that in the event of the insolvency of the ceding insurer, the reinsurance will be payable under the contract without diminution because of that insolvency.

Payments by the reinsurer must be made directly to its receiver or successor, except where the contract of insurance or reinsurance specifically provides for another payee for the reinsurance in the event of insolvency of the ceding insurer according to the applicable requirements of statutes, rules, or orders of the domiciliary state of the ceding insurer.

Subd. 12. **Concentration risk.** (a) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the commissioner within 30 days after reinsurance recoverables from a single assuming insurer, or group of affiliated assuming insurers, exceeds 50 percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from a single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer.

(b) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within 30 days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than 20 percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate that the exposure is safely managed by the domestic ceding insurer.

Subd. 13. **Suspension or revocation by commissioner.** (a) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(b) The commissioner must give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the commissioner's order on hearing, unless:

(1) the reinsurer waives its right to a hearing;

(2) the commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subdivision 10, paragraph (p); or

(3) the commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(c) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit, except to the extent that the reinsurer's obligations under the contract are secured in accordance with section 60A.093. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation, except to the extent that the reinsurer's obligations under the contract are secured in accordance with subdivision 10, paragraphs (j) to (o), or section 60A.093.

History: *1991 c 325 art 1 s 12; 1992 c 540 art 2 s 3; 1994 c 426 s 1; 1999 c 177 s 8,9; 2009 c 79 art 5 s 1; 2018 c 125 s 2; 1Sp2021 c 4 art 3 s 1,2*

60A.0921 CREDIT FOR REINSURANCE; CERTIFIED REINSURERS.

Subdivision 1. **Certified reinsurers; credit allowed.** (a) Credit for reinsurance shall be allowed from a domestic ceding insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with sections 60A.092, subdivision 10, and 60A.093. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

Ratings	Security Required
Secure - 1	0%
Secure - 2	10%
Secure - 3	20%
Secure - 4	50%
Secure - 5	75%
Vulnerable - 6	100%

(b) Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

(c) The commissioner shall require the certified reinsurer to post 100 percent, for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer.

(d) In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability

reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner. The one-year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the National Association of Insurance Commissioners (NAIC) annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

(1) Line 1: Fire;

(2) Line 2: Allied Lines;

(3) Line 3: Farmowners multiple peril;

(4) Line 4: Homeowners multiple peril;

(5) Line 5: Commercial multiple peril;

(6) Line 9: Inland Marine;

(7) Line 12: Earthquake;

(8) Line 21: Auto physical damage.

(e) Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

(f) Nothing in this section prohibits the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this section.

Subd. 2. **Certification procedure.** (a) The commissioner shall post notice on the department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least 30 days after posting the notice.

(b) The commissioner shall issue written notice to an assuming insurer that has applied and been approved as a certified reinsurer. The notice must include the rating assigned the certified reinsurer in accordance with subdivision 1. The commissioner shall publish a list of all certified reinsurers and their ratings.

(c) In order to be eligible for certification, the assuming insurer must:

(1) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner under subdivision 3;

(2) maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with paragraph (d), clause (8). This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents net of liabilities of at least $250,000,000 and a central fund containing a balance of at least $250,000,000;

(3) maintain financial strength ratings from two or more rating agencies acceptable to the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming

insurer and shall not be based solely on publicly available information. These financial strength ratings shall be one factor used by the commissioner in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

(i) Standard & Poor's;

(ii) Moody's Investors Service;

(iii) Fitch Ratings;

(iv) A.M. Best Company; or

(v) any other nationally recognized statistical rating organization; and

(4) ensure that the certified reinsurer complies with any other requirements reasonably imposed by the commissioner.

(d) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to:

(1) certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The commissioner shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification;

Ratings	Best	S&P	Moody's	Fitch
Secure - 1	A++	AAA	Aaa	AAA
Secure - 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure - 3	A	A+, A	A1, A2	A+, A
Secure - 4	A-	A-	A3	A-
Secure - 5	B++, B-	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable - 6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

(2) the business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

(3) for certified reinsurers domiciled in the United States, a review of the most recent applicable NAIC annual statement;

(4) for certified reinsurers not domiciled in the United States, a review annually of such forms as may be required by the commissioner;

(5) the reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than 90 days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

(6) regulatory actions against the certified reinsurer;

(7) the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in clause (8);

(8) for certified reinsurers not domiciled in the United States, audited financial statements (audited United States GAAP basis if available, audited IFRS basis statements are allowed, but must include an audited footnote reconciling equity and net income to a United States GAAP basis, or, with permission of the commissioner, audited IFRS statements with reconciliation to United States GAAP certified by an officer of the company). Upon the initial application for certification, the commissioner will consider audited financial statements for the last two years filed with its non-United States jurisdiction supervisor;

(9) the liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;

(10) a certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves United States ceding insurers. The commissioner must receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and

(11) other information as determined by the commissioner.

(e) Based on the analysis conducted under paragraph (d), clause (5), of a certified reinsurer's reputation for prompt payment of claims, the commissioner may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to United States ceding insurers, provided that the commissioner shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under paragraph (d), clause (1), if the commissioner finds that:

(1) more than 15 percent of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of 90 days or more which are not in dispute and which exceed $100,000 for each cedent; or

(2) the aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by 90 days or more exceeds $50,000,000.

(f) The assuming insurer must submit such forms as required by the commissioner as evidence of its submission to the jurisdiction of this state, appoint the commissioner as an agent for service of process in this state, and agree to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment. The commissioner shall not certify an assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final United States judgments or arbitration awards.

(g) The certified reinsurer must agree to meet filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis. All data submitted by certified reinsurers to the commissioner is nonpublic under section 13.02, subdivision 9. The certified reinsurer must file with the commissioner:

(1) a notification within ten days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license, or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefore;

(2) an annual report regarding reinsurance assumed, in a form determined by the commissioner;

(3) an annual report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in clause (4);

(4) an annual audited financial statement, regulatory filings, and actuarial opinion filed with the certified reinsurer's supervisor. Upon the initial certification, audited financial statements for the last two years filed with the certified reinsurer's supervisor;

(5) at least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from United States domestic ceding insurers;

(6) a certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and

(7) any other relevant information as determined by the commissioner.

Subd. 3. **Change in rating or revocation of certification.** (a) In the case of a downgrade by a rating agency or other disqualifying circumstance, the commissioner shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of subdivision 2, paragraph (d).

(b) The commissioner may suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the commissioner to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.

(c) If the rating of a certified reinsurer is upgraded by the commissioner, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the commissioner shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the commissioner, the commissioner shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

(d) Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with section 60A.093 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with section 60A.092, the commissioner may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

Subd. 4. **Qualified jurisdictions.** (a) If, upon conducting an evaluation under this section with respect to the reinsurance supervisory system of any non-United States assuming insurer, the commissioner determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the commissioner shall publish

notice and evidence of such recognition in an appropriate manner. The commissioner may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

(b) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the reinsurance supervisory system of the non-United States jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. The commissioner shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the commissioner as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the commissioner, include but are not limited to:

(1) the framework under which the assuming insurer is regulated;

(2) the structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance;

(3) the substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction;

(4) the form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used;

(5) the domiciliary regulator's willingness to cooperate with United States regulators in general and the commissioner in particular;

(6) the history of performance by assuming insurers in the domiciliary jurisdiction;

(7) any documented evidence of substantial problems with the enforcement of final United States judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final United States judgments or arbitration awards;

(8) any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or a successor organization; and

(9) other matters as determined by the commissioner.

(c) A list of qualified jurisdictions shall be published through the NAIC committee process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification with respect to the criteria provided under paragraph (b).

(d) United States jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

Subd. 5. **Recognition of certification issued by an NAIC-accredited jurisdiction.** (a) If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the commissioner may defer to that jurisdiction's certification, and to the rating assigned by that jurisdiction, if the assuming insurer submits information in the form required by the commissioner. The assuming insurer shall be considered to be a certified reinsurer in this state.

(b) Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this state as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the commissioner of any change in its status or rating within ten days after receiving notice of the change.

(c) The commissioner may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with subdivision 2, paragraph (d).

(d) The commissioner may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the commissioner suspends or revokes the certified reinsurer's certification in accordance with subdivision 3, the certified reinsurer's certification shall remain in good standing in this state for a period of three months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this state.

Subd. 6. **Mandatory funding clause.** In addition to the requirements of section 60A.092, subdivision 11, reinsurance contracts entered into or renewed under this section must include a requirement that the certified reinsurer provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

Subd. 7. **Commissioner requirement.** The commissioner must comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

History: *2018 c 125 s 3; 1Sp2021 c 4 art 3 s 3*

60A.093 REDUCTION FROM LIABILITY FOR REINSURANCE CEDED BY A DOMESTIC INSURER; COLLATERAL REQUIREMENTS.

Subdivision 1. **Reduction allowed.** A reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 60A.092 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, as security for the payment of obligations under the reinsurance contract with the assuming insurer. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution. The funds held as security may be in any form of security acceptable to the commissioner or in the form of:

(1) cash;

(2) securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets and, with the exception of United States treasury notes, readily marketable over a national exchange or NASDAQ with maturity dates within one year; or

(3) clean, irrevocable, unconditional letters of credit issued or confirmed by a qualified United States financial institution no later than December 31 in respect of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement.

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

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

History: *1991 c 325 art 1 s 13; 1995 c 214 s 4; 2018 c 125 s 4*

60A.094 RULES.

The commissioner may adopt rules implementing the provisions of sections 60A.091 to 60A.093.

History: *1991 c 325 art 1 s 14*

60A.095 REINSURANCE AGREEMENTS AFFECTED.

Sections 60A.091 to 60A.093 apply to all cessions after July 1, 1991, under reinsurance agreements that have had an inception, anniversary, or renewal date not less than six months after July 1, 1991.

History: *1991 c 325 art 1 s 15*

60A.096 QUALIFYING LETTER OF CREDIT.

Subdivision 1. **Generally.** An admitted asset or a reduction in liability for reinsurance ceded to an unauthorized assuming insurer providing a letter of credit pursuant to section 60A.093 shall only be allowed when the letter of credit meets the requirements of this section.

Subd. 2. **Content.** The letter of credit must be clean, irrevocable, and unconditional and issued or confirmed by a qualified United States financial institution as defined in section 60A.091. The letter of credit must contain an issue date and date of expiration and must stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit must also state that it is not subject to any condition or qualification outside of the letter of credit. In addition, the letter of credit must not contain reference to any other agreements, documents, or entities, except as provided in subdivision 10, paragraph (a).

As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, including conservator, rehabilitator, or liquidator.

Subd. 3. **Form.** The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section must be clearly marked to indicate that the information is for internal identification purposes only.

Subd. 4. **Reimbursement contingency prohibited.** The letter of credit must contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect to it.

Subd. 5. **Expiration.** The term of the letter of credit must be for at least one year and must contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" must provide for a period of no less than 30 days' notice before the expiration date or nonrenewal.

Subd. 6. **Governing law.** The letter of credit must state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 600) (UCP 600) or International Standby Practices of the International Chamber

of Commerce Publication 590 (ISP98), or any successor publication, and that all drafts drawn under it shall be presentable at an office in the United States of a qualified United States financial institution.

Subd. 7. **Extensions.** If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 600), or any successor publication, then the letter of credit must specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of Publication 600, or any other successor publication, occur.

Subd. 8. MS 2016 [Repealed by amendment, 2018 c 125 s 5]

Subd. 9. **Additional requirements.** If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in section 60A.093, then the following additional requirements must be met:

(1) the issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

(2) the "evergreen clause" must provide for no less than 30 days' notice before the expiration date or nonrenewal.

Subd. 10. **Reinsurance agreements provisions.** (a) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which:

(1) require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

(2) stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and must be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons: to reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of these policies; to reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement; to fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement, including but not limited to, amounts for policy reserves, claims and losses incurred, and unearned premium reserves; and to pay any other amounts the ceding insurer claims are due under the reinsurance agreement; and

(3) provide that all of the provisions of this paragraph should be applied without diminution because of insolvency of the ceding insurer or assuming insurer.

(b) Nothing in this subdivision precludes the ceding insurer and assuming insurer from providing for:

(1) an interest payment, at a rate not in excess of the prime rate of interest, on the amounts held under paragraph (a), clause (2); and

(2) the return of any amounts drawn down on the letters of credit in excess of the actual amounts required or, in the case of paragraph (a), clause (2), any amounts that are subsequently determined not to be due.

(c) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities, and health, where it is customary practice to provide a letter of credit for a specific

purpose, then the reinsurance agreement may, in lieu of paragraph (a), clause (2), require that the parties enter into a "trust agreement" which may be incorporated into the reinsurance agreement or be a separate document.

Subd. 11. **Limitation on use.** A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the commissioner unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

Subd. 12. MS 2016 [Repealed by amendment, 2018 c 125 s 5]

History: *1994 c 426 s 2; 2018 c 125 s 5*

60A.097 QUALIFYING TRUST AGREEMENTS.

Subdivision 1. **Requirements.** An admitted asset or a reduction in liability for reinsurance ceded to an unauthorized assuming insurer providing a trust fund pursuant to section 60A.093 shall only be allowed if the requirements of this section are met.

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given:

(a) "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, the named beneficiary includes and is limited to the court appointed domiciliary receiver, including a conservator, rehabilitator, or liquidator.

(b) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

(c) "Obligations" as used in subdivision 3, paragraph (k), means:

(1) reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

(2) reserves for reinsured losses reported and outstanding;

(3) reserves for reinsured losses incurred but not reported; and

(4) reserves for allocated reinsured loss expenses and unearned premiums.

"Obligations" excludes liabilities that are otherwise secured by acceptable means.

Subd. 3. **Required conditions.** (a) The trust agreement must be entered into between the beneficiary, the grantor, and a trustee which must be a qualified United States financial institution as defined in section 60A.091.

(b) The trust agreement must create a trust account into which assets must be deposited.

(c) All assets in the trust account must be held by the trustee at the trustee's office in the United States.

(d) The trust agreement must provide that:

(1) the beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(2) no other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(3) it is not subject to any conditions or qualifications outside of the trust agreement; and

(4) it shall not contain references to any other agreements or documents except as provided for under paragraph (k).

(e) The trust agreement must be established for the sole benefit of the beneficiary.

(f) The trust agreement must require the trustee to:

(1) receive assets and hold all assets in a safe place;

(2) determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate the assets, without consent or signature from the grantor or any other person or entity;

(3) furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(4) notify the grantor and the beneficiary within ten days of any deposits to or withdrawals from the trust account;

(5) upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(6) allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw the asset upon condition that the proceeds are paid into the trust account.

(g) The trust agreement must provide that at least 30 days, but not more than 45 days, before termination of the trust account, written notification of termination must be delivered by the trustee to the beneficiary.

(h) The trust agreement must be made subject to and governed by the laws of the state in which the trust is established.

(i) The trust agreement must prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(j) The trust agreement must provide that the trustee is liable for its own negligence, willful misconduct, or lack of good faith.

(k) Notwithstanding other provisions of this section, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may, notwithstanding any other conditions in this section, provide that the ceding insurer must undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer for the following purposes:

(1) to pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(2) to make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(3) where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days before the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in section 60A.091 apart from its general assets, in trust for the uses and purposes specified in clauses (1) and (2) that remain executory after the withdrawal and for any period after the termination date.

(l) Assets in the trust account must meet the requirements of section 60A.093, subdivision 1. The trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities, or accident and health risks, then the provisions required by this paragraph must be included in the reinsurance agreement.

(m) A letter of credit may be a trust asset if the trust agreement, deed of trust, or other binding agreement, as approved by the commissioner, provides that if the letter of trust expires without being renewed or replaced, the trustee must immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiary.

Subd. 4. **Permitted conditions.** (a) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice. No resignation or removal is effective until a successor trustee has been appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(b) The grantor may have the full and unqualified right to vote any shares or stock in the trust account and to receive from time to time payment of any dividends or interest upon any shares of stock or obligations included in the trust account. Interest or dividends must be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(c) The trustee may be given authority to invest, and accept substitutions of, any funds in the account. No investment or substitution must be made without prior approval of the beneficiary, unless the trust specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in subdivision 5, paragraph (a), clause (2).

(d) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. The transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(e) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered to the grantor.

Subd. 5. **Additional conditions applicable to reinsurance agreements.** (a) A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

(1) require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

(2) require the assuming insurer, before depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

(3) require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(4) stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and must be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of the company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(i) to reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of the policies;

(ii) to reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

(iii) to fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account must include, but not be limited to, amounts for policy reserves, claims and losses incurred, including losses incurred but not reported, loss adjustment expenses, and unearned premium reserves; and

(iv) to pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(b) The reinsurance agreement may also contain provisions that:

(1) give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, and provide that the ceding insurer shall not unreasonably or arbitrarily withhold its approval, provided:

(i) the assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(ii) after withdrawal and transfer, the current fair market value of the trust account is no less than 102 percent of the required amount;

(2) provide for:

(i) the return of any amount withdrawn in excess of the actual amounts required for paragraph (a), clause (4), items (i), (ii), and (iii), or in the case of paragraph (a), clause (4), item (iv), any amounts that are subsequently determined not to be due; and

(ii) interest payments, at a rate not in excess of the prime rate of interest, on the amounts; and

(3) permit the award by any arbitration panel or court of competent jurisdiction of:

(i) interest at a rate different from that provided in clause (2), item (ii);

(ii) court or arbitration costs;

(iii) attorney's fees; and

(iv) any other reasonable expenses.

Subd. 6. **Financial reporting.** A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the commissioner when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but the reduction must be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

Subd. 7. MS 2016 [Repealed by amendment, 2018 c 125 s 6]

Subd. 8. **Effect of failure to identify beneficiary.** The failure of any trust agreement to specifically identify the beneficiary, as defined in subdivision 2, paragraph (a), must not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the laws of this state.

History: *1994 c 426 s 3; 2018 c 125 s 6*

60A.10 DEPOSITS FOR PROTECTION OF POLICYHOLDERS.

Subdivision 1. **Domestic companies.** (1) **Deposit as security for all policyholders required.** No company in this state, other than farmers' mutual, or real estate title insurers, shall do business in this state unless it has on deposit with the commissioner, for the protection of both its resident and nonresident policyholders, securities to an amount, the actual market value of which, exclusive of interest, shall never be less than $500,000 or one-half the applicable financial requirement set forth in sections 60A.07, 66A.32, and 66A.33, whichever is less. The securities shall be retained under the control of the commissioner as long as any policies of the depositing company remain in force.

(2) **Securities defined.** For the purpose of this subdivision, the word "securities" means bonds or other obligations of, or bonds or other obligations insured or guaranteed by, the United States, any state of the United States, any municipality of this state, or any agency or instrumentality of the foregoing.

(3) **Protection of deposit from levy.** No judgment creditor or other claimant may levy upon any securities held on deposit with, or for the account of, the commissioner. Upon the entry of an order by a court of competent jurisdiction for the rehabilitation, liquidation or conservation of any depositing company as provided in chapter 60B, that company's deposit together with any accrued income thereon shall be transferred to the commissioner as rehabilitator, liquidator, or conservator.

Subd. 2. **Like requirement for foreign companies.** Any insurance company of any other state of the United States may file with the commissioner a certificate of the insurance commissioner of the other state that, as such officer, there is held in trust by the certifying commissioner and on deposit for the benefit of all the policyholders of the company a deposit of an amount not less than that required by subdivision 1 in par value of such securities as are required or permitted to be deposited by the laws of that state, these securities to be of the character in which insurance companies are authorized to invest under the laws of that state, stating the items of the securities so held, and that the commissioner is satisfied that these securities are worth the value so certified. No deposit shall be required in this state while the deposit, so certified, remains.

Subd. 2a. **Special deposits.** The commissioner may require a special deposit of an individual foreign insurer for the protection of its Minnesota policyholders or claimants. In the event of the filing of a delinquency petition against the insurer in Minnesota, the deposit is subject to chapters 60B, 60C, 61A, and 61B.

Subd. 3. **Deposits made in compliance with other laws or by foreign companies.** The commissioner shall receive and hold in official trust deposits made by any domestic company in compliance with the laws of any other state, to enable it to do business in that state, and in like manner hold deposits made by a foreign company under any law of this state. The company making the deposit shall be entitled to the income thereof and, from time to time, with the commissioner's consent, when not inconsistent with the law under which it was made, may exchange, in whole or in part, the securities composing the deposit for other approved securities of equal value. Upon application by a domestic company, the commissioner may return the whole or any portion of the securities so deposited by it, if satisfied that they are subject to no liability. Upon like application, the commissioner may return to a foreign company any deposit made by it when it appears that the company has ceased to do business in this state or the United States, and the commissioner is satisfied that it is not subject to any liability in this state, or upon the order of any court of competent jurisdiction. A foreign company which has made a deposit, its trustees, receiver, resident manager, or any creditor or policyholder thereof, may, at any time, institute in the District Court of Ramsey County an action against the state and other proper parties to enforce and terminate the trust created by the deposit. The commissioner shall immediately notify the governor of the action, and furnish the necessary information to answer in behalf of the state, and shall carry out such order and decree as the court shall make therein.

Subd. 4. **Safekeeping of securities on deposit.** No later than July 1, 1975, all securities held on deposit with the commissioner pursuant to the laws of this state, or in accordance with an order of the commissioner, shall be deposited for the account of the commissioner in such state or national bank in this state as the depositing insurer may designate and the commissioner may approve. Said deposits shall be made and maintained in accordance with a custodial agreement between the bank and the depositing insurer in a form approved by the commissioner which shall provide as a minimum that (1) the fees of the custodian are to be the obligation of the depositing insurer, and (2) there shall be no exchange, release or transfer of any deposited security unless the commissioner has assented thereto in writing. Securities evidenced by the Federal Reserve book entry system or held in a clearing corporation, as that term is defined in section 60A.11, subdivision 10, must be deposited through an approved custodian or the commissioner of commerce for the account of the commissioner of commerce for the benefit of all policyholders of the depositor.

Subd. 5. [Repealed, 1969 c 494 s 4]

Subd. 6. **Rules.** The commissioner of commerce shall have the power to make such rules as may be necessary for the execution of the functions vested in the commissioner by this section.

History: *1967 c 395 art 1 s 10; 1969 c 494 s 3; 1974 c 425 s 1-3; 1978 c 465 s 4; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1Sp1985 c 10 s 50; 1986 c 444; 1986 c 455 s 5; 1991 c 325 art 10 s 5; 1992 c 540 art 2 s 4; 1999 c 177 s 10; 2005 c 69 art 2 s 18; 2014 c 198 art 4 s 4*

60A.101 [Repealed, 1988 c 674 s 22]

60A.11 INVESTMENTS PERMITTED FOR DOMESTIC COMPANIES.

Subdivision 1. **Requirement for payment of capital stock.** The capital of every stock company shall be paid in full, in cash, within six months from the date of its certificate of incorporation, and thereupon a majority of the directors shall certify, under oath, to the commissioner that such payment, in cash, has been made by the stockholders for their respective shares, and is held as the capital of the company, and until then no policy shall be issued.

Subd. 2. [Repealed, 1981 c 211 s 42]

Subd. 3. [Repealed, 1981 c 211 s 42]

Subd. 4. [Repealed, 1981 c 211 s 42]

Subd. 5. [Repealed, 1981 c 211 s 42]

Subd. 5a. [Repealed, 1982 c 424 s 9]

Subd. 5b. [Repealed, 1982 c 424 s 9]

Subd. 6. [Repealed, 1981 c 211 s 42]

Subd. 7. **Investments in name of company or nominee and prohibitions.** No officer, director, or member of any committee passing on investments shall borrow any of such funds, or become, directly or indirectly, liable as a surety or endorser for or on account of loans thereof to others, or receive for personal use any fee, brokerage, commission, gift, or other consideration for, or on account of, any loan made by or on behalf of the company.

Subd. 8. [Repealed, 1981 c 211 s 42]

Subd. 9. **General considerations.** The following considerations apply in the interpretation of this section:

(a) this section applies to the investments of insurance companies other than life and health insurance companies;

(b) the purpose of this section is to protect and further the interests of policyholders, claimants, creditors and the public by providing standards for the development and administration of programs for the investment of the assets of domestic companies. These standards and the investment programs developed by companies must take into account the safety of company's principal, investment yield and growth, stability in the value of the investment, the liquidity necessary to meet the company's expected business needs, and investment diversification;

(c) all financial terms relating to insurance companies have the meanings assigned to them under statutory accounting methods. All financial terms relating to noninsurance companies have the meanings assigned to them under generally accepted accounting principles;

(d) investments must be valued in accordance with the valuation procedures established by the National Association of Insurance Commissioners, unless the commissioner requires or finds another method of valuation reasonable under the circumstances. Another method of valuation permitted by the commissioner must be at least as conservative as those prescribed in the association's manual. Other invested assets must be valued according to the procedures promulgated by the National Association of Insurance Commissioners, if not addressed in another section, unless the commissioner requires or finds another method of valuation reasonable under the circumstances;

(e) a company may elect to hold an investment which qualifies under more than one subdivision, under the subdivision of its choice. Nothing herein prevents a company from electing to hold an investment under a subdivision different from the one in which it previously held the investment; and

(f) an investment which qualifies under any provision of the law governing investments of insurance companies when acquired will continue to be a qualified investment for as long as it is held by the insurance company.

Subd. 10. **Definitions.** The following terms have the meanings assigned in this subdivision for purposes of this section:

(a) "adequate evidence" means a written confirmation, advice, or other verification issued by a depository, issuer, or custodian bank which shows that the investment is held for the company;

(b) "adequate security" means a letter of credit qualifying under subdivision 11, paragraph (f), cash, or the pledge of an investment authorized by any subdivision of this section;

(c) "admitted assets," for purposes of computing percentage limitations on particular types of investments, means the assets as shown by the company's annual statement, required by section 60A.13, as of the December 31 immediately preceding the date the company acquires the investment;

(d) "clearing corporation" means The Depository Trust Company or any other clearing agency registered with the Securities and Exchange Commission pursuant to the Securities Exchange Act of 1934, section 17A, Euro-clear Clearance System Limited and CEDEL S.A., and, with the approval of the commissioner, any other clearing corporation as defined in section 336.8-102;

(e) "control" has the meaning assigned to that term in, and must be determined in accordance with, section 60D.15, subdivision 4;

(f) "custodian bank" means a bank or trust company or a branch of a bank or trust company that is acting as custodian and is supervised and examined by state or federal authority having supervision over the bank or trust company or with respect to a company's foreign investments only by the regulatory authority having supervision over banks or trust companies in the jurisdiction in which the bank, trust company, or branch is located, and any banking institutions qualifying as an "Eligible Foreign Custodian" under the Code of Federal Regulations, section 270.17f-5, adopted under section 17(f) of the Investment Company Act of 1940, and specifically including Euro-clear Clearance System Limited and CEDEL S.A., acting as custodians;

(g) "evergreen clause" means a provision that automatically renews a letter of credit for a time certain if the issuer of the letter of credit fails to affirmatively signify its intention to nonrenew upon expiration;

(h) "government obligations" means direct obligations for the payment of money, or obligations for the payment of money to the extent guaranteed as to the payment of principal and interest by any governmental issuer where the obligations are payable from ad valorem taxes or guaranteed by the full faith, credit, and taxing power of the issuer and are not secured solely by special assessments for local improvements;

(i) "noninvestment grade obligations" means obligations which, at the time of acquisition, were rated below Baa/BBB or the equivalent by a securities rating agency or which, at the time of acquisition, were not in one of the two highest categories established by the Securities Valuation Office of the National Association of Insurance Commissioners;

(j) "issuer" means the corporation, business trust, governmental unit, partnership, association, individual, or other entity which issues or on behalf of which is issued any form of obligation;

(k) "licensed real estate appraiser" means a person who develops and communicates real estate appraisals and who holds a current, valid license under chapter 82B or a substantially similar licensing requirement in another jurisdiction;

(l) "member bank" means a national bank, state bank or trust company which is a member of the Federal Reserve System;

(m) "national securities exchange" means an exchange registered under section 6 of the Securities Exchange Act of 1934 or an exchange regulated under the laws of the Dominion of Canada;

(n) "NASDAQ" means the reporting system for securities meeting the definition of National Market System security as provided under Part I to Schedule D of the National Association of Securities Dealers Incorporated bylaws;

(o) "obligations" include bonds, notes, debentures, transportation equipment certificates, repurchase agreements, bank certificates of deposit, time deposits, bankers' acceptances, and other obligations for the payment of money not in default as to payments of principal and interest on the date of investment, whether constituting general obligations of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment. Leases are considered obligations if the lease is assigned for the benefit of the company and is nonterminable by the lessee or lessees thereunder upon foreclosure of any lien upon the leased property, and rental payments are sufficient to amortize the investment over the primary lease term;

(p) "qualified assets" means the sum of (1) all investments qualified in accordance with this section other than investments in affiliates and subsidiaries, (2) investments in obligations of affiliates as defined in section 60D.15, subdivision 2, secured by real or personal property sufficient to qualify the investment under subdivision 19 or 23, (3) qualified investments in subsidiaries, as defined in section 60D.15, subdivision 9, on a consolidated basis with the insurance company without allowance for goodwill or other intangible value, and (4) cash on hand and on deposit, agent's balances or uncollected premiums not due more than 90 days, investment income due and accrued, funds due or on deposit or recoverable on loss payments under contracts of reinsurance entered into pursuant to section 60A.09, premium bills and notes receivable, federal income taxes recoverable, and equities and deposits in pools and associations;

(q) "qualified net earnings" means that the net earnings of the issuer after elimination of extraordinary nonrecurring items of income and expense and before income taxes and fixed charges over the five immediately preceding completed fiscal years, or its period of existence if less than five years, has averaged not less than 1-1/4 times its average annual fixed charges applicable to the period;

(r) "replicated investment position" means the statement value of the position reported under the heading "Replicated (Synthetic) Asset" on Schedule DB, Part F, of the annual statement of the insurer, or any successor provision;

(s) "replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under this section. A derivative transaction that

either is authorized by subdivision 18, clause (5), or by subdivision 24, or is entered into as a hedging transaction shall not be considered a replication transaction;

(t) "required liabilities" means the sum of (1) total liabilities as required to be reported in the company's most recent annual report to the commissioner of commerce of this state, (2) for companies operating under the stock plan, the minimum paid-up capital and surplus required to be maintained pursuant to section 60A.07, subdivision 5a, (3) for companies operating under the mutual or reciprocal plan, the minimum amount of surplus required to be maintained pursuant to section 60A.07, subdivision 5b, and (4) the amount, if any, by which the company's loss and loss adjustment expense reserves exceed 350 percent of its surplus as it pertains to policyholders as of the same date. The commissioner may waive the requirement in clause (4) unless the company's written premiums exceed 300 percent of its surplus as it pertains to policyholders as of the same date. In addition to the required amounts pursuant to clauses (1) to (4), the commissioner may require that the amount of any apparent reserve deficiency that may be revealed by one-to-five-year loss and loss adjustment expense development analysis for the five years reported in the company's most recent annual statement to the commissioner be added to required liabilities;

(u) "revenue obligations" means obligations for the payment of money by a governmental issuer where the obligations are payable from revenues, earnings, or special assessments on properties benefited by local improvements of the issuer which are specifically pledged therefor;

(v) "security" has the meaning given in section 5 of the Security Act of 1933 and specifically includes, but is not limited to, stocks, stock equivalents, warrants, rights, options, obligations, American Depository Receipts (ADRs), repurchase agreements, and reverse repurchase agreements; and

(w) "unrestricted surplus" means the amount by which qualified assets exceed 110 percent of required liabilities.

Subd. 11. **Investments in name of company or nominee and prohibitions.** A company's investments shall be held in its own name or the name of its nominee, except that:

(a) Investments may be held in the name of a clearing corporation or of a custodian bank or in the name of the nominee of either on the following conditions:

(1) the clearing corporation, custodian bank, or nominee must be legally authorized to hold the particular investment for the account of others;

(2) where the investment is evidenced by a certificate and held in the name of a custodian bank or the nominee by a custodian bank, a written agreement shall provide that certificates so deposited shall at all times be kept separate and apart from other deposits with the depository, so that at all times they may be identified as belonging solely to the company making the deposit;

(3) where a clearing corporation is to act as depository, the investment may be merged or held in bulk in the clearing corporation's or its nominee name with other investments deposited with the clearing corporation by any other person, if a written agreement provides that adequate evidence of the deposit is to be obtained and retained by the company or a custodian bank; and

(4) the company shall monitor current publicly available financial information and other pertinent data with respect to the custodian banks.

(b) A company may loan securities held by it under this chapter to a broker-dealer registered under the Securities and Exchange Act of 1934 or a member bank. The loan must be evidenced by a written agreement which provides:

(1) that the loan will be fully collateralized by cash or obligations issued or guaranteed by the United States or an agency or an instrumentality thereof, and that the collateral will be adjusted each business day during the term of the loan to maintain the required collateralization in the event of market value changes in the loaned securities or collateral;

(2) that the loan may be terminated by the company at any time, and that the borrower will return the loaned securities or their equivalent within five business days after termination;

(3) that the company has the right to retain the collateral or use the collateral to purchase investments equivalent to the loaned securities if the borrower defaults under the terms of the agreement and that the borrower remains liable for any losses and expenses incurred by the company due to default that are not covered by the collateral.

(c) A company may participate through a member bank in the Federal Reserve book-entry system, and the records of the member bank shall at all times show that the investments are held for the company or for specific accounts of the company.

(d) An investment may consist of an individual interest in a pool of obligations or a fractional interest in a single obligation if the certificate of participation or interest or the confirmation of participation or interest in the investment shall be issued in the name of the company or the name of the custodian bank or the nominee of either and if the certificate or confirmation must, if held by a custodian bank, be kept separate and apart from the investments of others so that at all times the participation may be identified as belonging solely to the company making the investment.

(e) Except as provided in paragraph (c), where an investment is not evidenced by a certificate, adequate evidence of the company's investment shall be obtained from the issuer or its transfer or recording agent and retained by the company, a custodian bank, or clearing corporation. Transfers of ownership of investments held as described in paragraphs (a), clause (3), (c) and (d) may be evidenced by bookkeeping entry on the books of the issuer of the investment or its transfer or recording agent or the clearing corporation without physical delivery of certificates, if any, evidencing the company's investment.

(f) A letter of credit may be accepted as a guaranty of other investments, as collateral to secure loans, or in lieu of cash to secure loans of securities, if it is issued by a member bank or any of the 100 largest banks in the world ranked by deposits in dollars or converted into dollar equivalents, as compiled annually by the American Bankers Association or listed in the annual publication of Moody's Bank & Finance Manual and meets the following requirements:

(1) has a long-term deposit rating or a long-term debt rating of at least Aa2 as found in the current monthly publication of Moody's Credit Opinions or its equivalent; and

(2) qualifies under the guidelines of the National Association of Insurance Commissioners as a clean, irrevocable letter of credit containing an evergreen clause or having a maturity date subsequent to the maturity date of the underlying investment or loan. The company shall monitor current publicly available financial information and other pertinent data with respect to the banks issuing the letters of credit.

Subd. 11a. **Additional limitations.** Under the standards and procedures in sections 60G.20 to 60G.22 for individual insurers, the commissioner may impose additional limitations on all insurers on the types and percentages of investments as the commissioner determines necessary to protect and ensure the safety of the general public.

Subd. 12. **Investments.** (a) A company must comply with section 60A.112.

(b) A company's investments must be so diversified that the securities of a single issuer, other than the United States of America or any agency or instrumentality of the United States of America backed by the full faith and credit of the issuer, shall comprise no more than five percent of the company's admitted assets, except where otherwise specified under this chapter. In the case of insurance companies which are subsidiaries of a company, this diversification test must be applied to the assets of the insurance company subsidiary in determining the company's compliance.

(c) The investments authorized under subdivisions 12 to 26 shall constitute admitted assets for a company.

Subd. 13. **United States government obligations.** (a) Obligations issued or guaranteed by the United States of America or any agency or instrumentality of the United States of America backed by the full faith and credit of the issuer. Pursuant to section 106 of title I of the Secondary Mortgage Market Enhancement Act of 1984, United States Code, title 15, section 77r-1, included under this paragraph are obligations issued or guaranteed by the Federal Home Loan Mortgage Corporation and the Federal National Mortgage Association.

(b) Obligations issued or guaranteed by an agency or instrumentality of the United States of America other than those backed by the full faith and credit thereof, including rights to purchase or sell these obligations if those rights are traded upon a contract market designated and regulated by a federal agency. The securities of a single issuer under this paragraph shall comprise no more than 20 percent of the company's admitted assets.

Subd. 14. **Certain bank obligations.** (a) Certificates of deposits, time deposits, and bankers' acceptances issued by and other obligations guaranteed by: (i) any bank organized under the laws of the United States or any state, commonwealth, or territory thereof, including the District of Columbia, or of the Dominion of Canada or any province thereof or (ii) any of the 100 largest banks, not a subsidiary or a holding company thereof, in the world ranked by deposits in dollars or converted into dollar equivalents, as compiled annually by the American Bankers Association or listed in the annual publication of Moody's Bank & Finance Manual, which also has a long-term deposit rating or a long-term debt rating of at least Aa2 as found in the current monthly publication of Moody's Credit Opinions or its equivalent. A company may not invest more than five percent of its admitted assets in the obligations of any one bank and may not hold at any time more than ten percent of the outstanding obligations of any one bank.

(b) Obligations issued or guaranteed by the International Bank for Reconstruction and Development, the Asian Development Bank, the Inter-American Development Bank, the African Development Bank, the Export-Import Bank, the World Bank or any United States government sponsored organization of which the United States is a member, if the principal and interest is payable in United States dollars. A company may not invest more than five percent of its total admitted assets in the obligations of any one of these banks or organizations, and may not invest more than a total of 15 percent of its total admitted assets in the obligations of all these banks and organizations.

Subd. 15. **State obligations.** (a) Government obligations issued or guaranteed by any state, commonwealth, or territory of the United States of America or by any political subdivision thereof, including the District of Columbia, or by any instrumentality of any state, commonwealth, territory, or political subdivision thereof. The diversification requirement of subdivision 12, paragraph (b), does not apply to government obligations under this paragraph.

(b) Revenue obligations issued by any state, commonwealth, or territory of the United States of America or by any political subdivision thereof, including the District of Columbia, or by any instrumentality of any

state, commonwealth, territory, or political subdivision thereof. The diversification requirement of subdivision 12, paragraph (b), is applicable to revenue obligations under this paragraph.

Subd. 16. **Canadian government obligations.** (a) Obligations issued or guaranteed by the Dominion of Canada or by any agency or instrumentality of the Dominion of Canada backed by the full faith and credit of the issuer. The diversification requirement of subdivision 12, paragraph (b), does not apply to government obligations under this paragraph.

(b) Obligations issued or guaranteed by an agency or instrumentality of the Dominion of Canada other than those backed by the full faith and credit of the issuer. The securities of a single issuer under this paragraph shall comprise no more than 20 percent of the company's admitted assets.

(c) Government obligations issued or guaranteed by a province or territory of the Dominion of Canada or by a political subdivision thereof, or by an instrumentality of a province, territory, or political subdivision thereof. The diversification requirement of subdivision 12, paragraph (b), does not apply to government obligations under this paragraph.

(d) Revenue obligations issued by a province or territory of the Dominion of Canada or by a political subdivision thereof, or by an instrumentality of a province, territory, or political subdivision thereof. The diversification requirement of subdivision 12, paragraph (b), is applicable to revenue obligations under this paragraph.

Subd. 17. **Corporate and business trust obligations.** Obligations issued, assumed or guaranteed by a corporation or business trust organized under the laws of the United States of America or any state, commonwealth, or territory of the United States, including the District of Columbia, or the laws of the Dominion of Canada or any province or territory of the Dominion of Canada, or obligations traded on a national securities exchange on the following conditions:

(a) a company may invest in any obligations traded on a national securities exchange;

(b) a company may also invest in any obligations which are secured by adequate security located in the United States or Canada;

(c) a company may also invest in previously outstanding or newly issued obligations not qualifying for investment under paragraph (a) or (b) if the corporation or business trust has qualified net earnings. If the obligations are not newly issued, neither principal nor interest payments on the obligations shall have been in arrears (1) for an aggregate of 90 days during the three-year period preceding the date of investment, or (2) where the obligations have been outstanding for less than 90 days, during the period the obligations have been outstanding;

(d) a company may invest no more than 15 percent of its total admitted assets in noninvestment grade obligations;

(e) a company may invest in federal farm loan bonds and may invest up to 20 percent of its total admitted assets in the obligations of farm mortgage debenture companies; and

(f) a company may not invest more than five percent of its admitted assets in the obligations of any one corporation or business trust; provided, however, that a company may invest in the obligations of a corporation without regard to this paragraph or the subdivision 12, paragraph (b), diversification requirement if: (1) the company is wholly owned by the issuer and affiliates of the issuer of the obligations; (2) the company insures solely the issuer of the obligations and its affiliates; (3) the issuer has a net worth, determined on a consolidated basis, which equals or exceeds $100,000,000; and (4) the issuer and its affiliates forgo any and all claims

they may have against the Minnesota Insurance Guaranty Association pursuant to chapter 60C in the event of the insolvency of the company. This does not affect the rights of any unaffiliated third-party claimant under section 60C.09, subdivision 1.

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

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

(2) a company may not invest in more than two percent of its total admitted assets in preferred stocks of any corporation which are traded on a national securities exchange and may also invest in other preferred stocks if the issuer has qualified net earnings and if current or cumulative dividends are not then in arrears;

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

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

(5) a company may invest in warrants and rights granted by an issuer to purchase securities of the issuer if that security of the issuer, at the time of the acquisition of the warrant or right to purchase, would qualify

as an investment under paragraph (a), clause (2) or (3), whichever is applicable, provided that security meets the standards prescribed in the clause at the time of acquisition of the securities; and

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

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

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

Subd. 19. **Mortgages on real estate.** Up to 25 percent of a company's total admitted assets may be invested in loans or obligations secured by a mortgage or a trust deed on real estate located in any state, commonwealth, or territory of the United States, including the District of Columbia, or in any province or territory of the Dominion of Canada, on the following conditions:

(a) a leasehold estate constitutes real estate under this section if its unexpired term on the date of investment is at least five years longer than the term of the obligation secured by it. The obligation must be repayable within the leasehold term in annual or more frequent installments, except that obligations for commercial purposes may begin up to five years after the date of the obligations. The mortgage must entitle the company upon default to be subrogated to all rights of the lessor under the leasehold;

(b) the real estate to which the mortgage applies must be (1) improved with permanent buildings, or (2) used for agriculture or pasture, or (3) income-producing, including but not limited to parking lots and leases, royalty or other mineral interests in properties producing oil, gas or other minerals and interests in properties for the harvesting of forest products, or (4) subject to a definite plan for the commencement of development within five years;

(c) the real estate to which the mortgage applies must be otherwise unencumbered when the mortgage loan is funded except as provided in paragraph (d) and except for encumbrances which do not unreasonably interfere with the intended use of the real estate as security;

(d) the real estate to which the mortgage applies may be subject to a prior mortgage or trust deed if (1) the amount of the obligation is equal to the sum of the company's loan and the other outstanding indebtedness and (2) the company has control over the payments under the prior mortgage or trust deed;

(e) the amount of the obligation may not exceed 80 percent of the real estate. If the amount of the obligation exceeds 66-2/3 percent of the market value of the real estate, principal payments must commence within five years after the date of the mortgage loan and principal and interest on the loan shall be fully amortized by regular installments payable during the term of the loan without irregular or balloon payments, unless the schedule of irregular or balloon payments is more favorable to the insurer than regular installments of equal amount would be. The market value shall be established by the written certification of a licensed real estate appraiser qualified to appraise the particular type of real estate involved. The appraisal must be required at the time the loan is made;

(f) the maximum term of any obligation shall be 40 years, except as provided in paragraph (g) and except for obligations secured by a mortgage or trust deed which are or are to be insured by a private mortgage insurance company approved by the commissioner;

(g) the 25 percent of total admitted asset limitation in the preamble of this subdivision and the maximum amount and term limitations in paragraphs (e) and (f) shall not apply to obligations secured by mortgage or trust deed which are insured or guaranteed by the United States of America or any agency or instrumentality of the United States;

(h) a company may invest in collateralized mortgage obligations, mortgage participation certificates and pools issued or administered by a bank or banks and secured by first mortgages or trust deeds on improved real estate located in the United States provided the private placement memorandum, prospectus or other offering circular, or a written agreement with the issuer of the collateralized mortgage obligations, certificate or other pool interest provides that each loan meets the requirements of this subdivision;

(i) notwithstanding the restrictions in paragraph (e), if a company disposes of real estate acquired by it under subdivision 20, it may take back a purchase money mortgage from its purchaser in an amount up to 90 percent of the appraised value; and

(j) the vendor's equity in a contract for deed shall be treated as a mortgage for purposes of this subdivision.

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

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

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

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

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

All the real estate specified in clauses (1) to (3) must be sold and disposed of within five years after the company has acquired title to it, or within five years after it has ceased to be necessary for the accommodation

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

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

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

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

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

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

Subd. 21. **Foreign investments.** Obligations of and investments in foreign countries, on the following conditions:

(a) a company may acquire and hold any foreign investments which are required as a condition of doing business in the foreign country or necessary for the convenient accommodation of its foreign business. An investment is considered necessary for the convenient accommodation of the insurance company's foreign business only if it is demonstrably and directly related in size and purpose to the company's foreign insurance operations; and

(b) a company may also invest not more than five percent of its total admitted assets in any combination of:

(1) the obligations of foreign governments, corporations, or business trusts;

(2) obligations of federal, provincial, or other political subdivisions backed by the full faith and credit of the foreign governmental unit;

(3) or in the stocks or stock equivalents or obligations of foreign corporations or business trusts not qualifying for investment under subdivision 12, if the obligations, stocks or stock equivalents are listed or

regularly traded on the London, Paris, Zurich, or Tokyo stock exchange or any similar regular securities exchange not disapproved by the commissioner within 30 days' following notice from the company of its intention to invest in these securities.

Subd. 22. **Personal property under lease.** Personal property for intended lease or rental in the United States or Canada. A company may not invest more than five percent of its total admitted assets under this subdivision. In cases where the asset leased would otherwise be nonadmitted, the asset or associated lease is nonadmitted.

Subd. 23. **Collateral loans.** Obligations having adequate security if:

(a) the collateral is legally assigned or delivered to the company;

(b) the company has the right to declare the obligation immediately due and payable if the security thereafter depreciates to the point where the investment would not qualify under paragraph (c); provided, that additional qualifying security may be pledged to allow the investment to remain qualified at its face value;

(c) the collateral must at the time of delivery or assignment have a market value of at least, in the case of cash, or a letter of credit meeting the requirements of subdivision 11, paragraph (f), equal to and, in all other cases, 1-1/4 times the amount of the unpaid balance of the obligations.

A collateral loan made by a company to its parent corporation or an affiliated party must be secured by collateral: (i) with a market value equal to the amount of the unpaid balance of the obligations, and (ii) which is issued or guaranteed by the United States of America or an agency or an instrumentality thereof, or any state or territory thereof, and is secured by the full faith and credit of the United States of America or any state or territory thereof. A company may not invest more than five percent of its total admitted assets under this subdivision.

Subd. 24. **Options.** (a) A company may sell exchange-traded call options against stocks or other securities owned by the company and may purchase exchange-traded call options in a closing transaction against a call option previously written by the company.

(b) A company may purchase or sell other exchange-traded call options and may sell or purchase exchange-traded put options only if, to the extent and on terms and conditions the commissioner determines to be consistent with the purposes of this section.

Subd. 24a. [Repealed, 1999 c 177 s 88]

Subd. 25. **Unrestricted surplus.** A company may invest its unrestricted surplus, in securities or property of any kind, without restriction or limitation except as may be imposed on business corporations in general.

Subd. 25a. **Replication transactions.** An insurer engaging in replication transactions shall include all replicated investment positions in calculating compliance with the limitations on investments applicable to the insurer. Replication transactions are permitted only under the authority of subdivision 25. An insurer may invest its unrestricted surplus in a replication transaction only to the extent that the replicated investment position does not cause the total positions represented by the unrestricted surplus to be greater than the total positions represented by the unrestricted surplus as would be permitted in the absence of the replicated investment position.

Subd. 26. **Rules.** (a) The commissioner may adopt appropriate rules to carry out the purpose and provisions of this section.

(b) A company may make qualified investments in any other type of investment or exceeding any limitations of quality, quantity, or percentage of admitted assets contained in this section with the written order of the commissioner. This approval is at the discretion of the commissioner, provided that the additional investments allowed by the commissioner's written order may not exceed five percent of the company's admitted assets.

(c) Nothing authorized in this subdivision negates or reduces the investment authority granted in subdivisions 1 to 25.

History: *1967 c 395 art 1 s 11; 1969 c 7 s 14-16; 1969 c 494 s 5-11; 1974 c 64 s 4,5; 1978 c 465 s 5; 1981 c 211 s 9-26,42; 1Sp1981 c 4 art 4 s 6,7; 1982 c 424 s 10,11; 1982 c 622 s 1; 1983 c 289 s 114 subd 1; 1983 c 340 s 1-8; 1984 c 382 s 3; 1984 c 655 art 1 s 92; 1Sp1985 c 16 art 2 s 17; 1986 c 444; 1987 c 189 s 1,2; 1991 c 325 art 8 s 1-17; art 10 s 6; 1992 c 540 art 2 s 5,6; 1993 c 13 art 2 s 1; 1993 c 299 s 1; 1994 c 425 s 2; 1995 c 214 s 5,6; 1996 c 446 art 2 s 5; 2000 c 350 s 1; 2001 c 131 s 1,2; 2001 c 215 s 3; 2008 c 240 s 6; 2019 c 50 art 1 s 16*

60A.111 [Repealed, 2001 c 215 s 41]

60A.112 INVESTMENT POLICY REQUIRED.

Each domestic company must have a written investment policy, designed to provide guidance for investment decisions by management. The policy must be approved by its board of directors. The policy must be reviewed by the company's board of directors and reapproved no less often than once every 12 months. The investment policy must address asset type diversification, diversification within asset types, concentration risks, interest rate risk, liquidity, foreign investments, loans secured by real estate, and investment real estate. The policy must set forth, in detail, company practices relating to internal controls regarding the delegation of investment authority within the company.

The board of directors must also determine at least annually the extent to which the company has complied with its investment policy within the preceding 12 months and shall adopt a written determination.

The company must file, as an attachment to its annual statement, a certification that:

(1) the company has a written investment policy meeting the requirements of this section;

(2) the company's board of directors has reviewed and approved or reapproved the policy within the period covered by the annual statement; and

(3) the company's board of directors performed the compliance review and made the written determination required by this section for the period covered by the annual statement.

A company's failure to meet the requirements of this section does not affect its ability to enforce its legal or equitable rights with respect to its investments.

History: *1991 c 325 art 18 s 1; 1992 c 540 art 2 s 7*

60A.12 ASSETS AND LIABILITIES.

Subdivision 1. [Repealed, 2000 c 350 s 16]

Subd. 2. [Repealed, 1991 c 325 art 8 s 18]

Subd. 3. [Repealed, 2000 c 350 s 16]

Subd. 4. [Repealed, 2000 c 350 s 16]

Subd. 5. **Loss reserves.** When, in the judgment of the commissioner, the loss reserves, calculated in accordance with statutory accounting practices as set forth in the National Association of Insurance Commissioners' accounting practices and procedures manual are inadequate, the commissioner may require the corporation to maintain additional reserves.

Subd. 6. [Repealed, 1978 c 465 s 15]

Subd. 7. [Repealed, 2000 c 350 s 16]

Subd. 8. [Repealed, 2000 c 350 s 16]

Subd. 9. [Repealed, 2000 c 350 s 16]

Subd. 10. [Repealed, 1993 c 299 s 33]

History: *1967 c 395 art 1 s 12; 1975 c 359 s 23; 1978 c 465 s 6; 1986 c 444; 1991 c 325 art 16 s 1; 1992 c 540 art 2 s 8; 1992 c 564 art 1 s 17,54; 1993 c 299 s 2; 2000 c 350 s 2*

60A.121 VALUATIONS; DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to sections 60A.121 to 60A.127.

Subd. 2. **Commercial mortgage loan.** "Commercial mortgage loan" means a loan by an insurer secured by a mortgage on commercial real estate. "Commercial mortgage loan" does not include loans secured by residential real estate containing four or fewer dwelling units or agricultural real estate.

Subd. 2a. **Contractual terms.** "Contractual terms" means the principal and interest payments of the commercial mortgage loan as scheduled in the mortgage agreement.

Subd. 3. **Delinquent mortgage loan.** "Delinquent mortgage loan" means a loan 90 days delinquent on a required payment of principal or interest.

Subd. 4. **Distressed mortgage loan.** "Distressed mortgage loan" means a loan, other than a delinquent loan, that is determined by the management of the insurer, in the exercise of its prudent investment judgment, to involve circumstances that create a reasonable probability that the loan may become a delinquent mortgage loan or a mortgage loan in foreclosure.

Subd. 5. **Independent appraiser.** "Independent appraiser" means a person not employed by the insurer, by an affiliate of the insurer, or by an investment advisor to the insurer who develops and communicates real estate appraisals and holds a current, valid license issued under section 82B.08, or a similar law enacted by another state.

Subd. 6. **Internal appraisal.** "Internal appraisal" means an appraisal to determine current market value made by an internal appraiser and based upon an evaluation of:

(1) the property based upon a physical inspection of the premises;

(2) the current and expected stabilized cash flow generated by the property;

(3) the current and expected stabilized market rents in the geographic market where the property is located; and

(4) the current and stabilized occupancy rates for the geographic market where the property is located.

Subd. 7. **Internal appraiser.** "Internal appraiser" means an individual:

(1) employed by an insurer, by an affiliate of the insurer, or by an investment advisor to an insurer;

(2) who has training and experience qualifying the individual to appraise the value of commercial real estate;

(3) whose direct or indirect compensation is not dependent upon the outcome of the appraisals performed under sections 60A.121 to 60A.126; and

(4) who has direct reporting access to the chief investment officer of the insurer.

Subd. 8. **Insurer.** "Insurer" means a domestic insurance company.

Subd. 9. **Mortgage loan in foreclosure.** "Mortgage loan in foreclosure" means (1) a loan in the process of foreclosure including the time required for expiration of any equitable or statutory redemption rights; (2) a loan to a mortgagor who is the subject of a bankruptcy petition and who is not making payments according to the contractual terms; or (3) a loan secured by a mortgage on real estate that is subject to a senior mortgage or other lien that is being foreclosed.

Subd. 10. **Performing mortgage loan.** "Performing mortgage loan" means a mortgage loan current in payment and not in distress.

Subd. 10a. **Permanently impaired.** A commercial mortgage loan will be "permanently impaired" when, based on current information and events, it is probable that an insurer will be unable to collect all amounts due according to the contractual terms.

Subd. 11. **Real estate owned.** "Real estate owned" means real property owned and acquired by an insurer through or in lieu of foreclosure and as to which all equitable or statutory rights of redemption have expired.

Subd. 12. **Restructured mortgage loan.** "Restructured mortgage loan" means a loan where:

(1) material delinquent payments or accrued interest are capitalized and added to the balance of an outstanding loan; or

(2) the insurer has abated or reduced interest payments below market rates existing at the date of restructuring.

History: *1991 c 325 art 19 s 1; 2000 c 350 s 3-5; 2011 c 76 art 1 s 4*

60A.122 REQUIRED WRITTEN PROCEDURES FOR VALUATIONS.

An insurer shall establish written procedures, approved by the company's board of directors, for the valuation of commercial mortgage loans and real estate owned. The procedures must be made available to the commissioner upon request. The commissioner shall review the insurer's compliance with the procedures in any examination of the insurer under section 60A.031.

History: *1991 c 325 art 19 s 2*

60A.123 VALUATION PROCEDURE.

Subdivision 1. **Requirement.** An insurer shall value its commercial mortgage loans and real estate acquired through foreclosure of commercial mortgage loans as provided in this section for the purpose of establishing a valuation allowance or fair values of the investments and for statutory accounting purposes.

Subd. 2. **Performing mortgage loan.** A performing mortgage loan must be carried at its amortized acquisition cost.

Subd. 3. **Distressed mortgage loan.** (a) The insurer shall make an evaluation of the appropriate fair value of its commercial mortgage loans which it classifies as distressed mortgage loans. The fair value must be based upon one or more of the following procedures:

(1) an internal appraisal;

(2) an appraisal made by an independent appraiser;

(3) the value of guarantees or other credit enhancements related to the loan.

(b) The insurer will determine the fair value of its distressed mortgage loans through an evaluation of each specific distressed mortgage loan. The fair value must be based upon an internal appraisal or an appraisal conducted by an independent appraiser.

(c) For distressed mortgage loans, the insurer shall measure impairment based on the fair value of the collateral less estimated costs to obtain and sell. A valuation allowance should be established for the difference between the adjusted fair value of the collateral and the amortized acquisition cost of its distressed mortgage loans.

Subd. 4. **Delinquent mortgage loan.** (a) The insurer shall make an evaluation of the appropriate fair value of each delinquent mortgage loan. The fair value must be based upon one or more of the following procedures:

(1) an internal appraisal;

(2) an appraisal by an independent appraiser;

(3) the value of guarantees or other credit enhancements related to the loan.

(b) The insurer shall either take a charge against its surplus or establish a reserve for the difference between the fair value and the amortized acquisition cost of its delinquent mortgage loans.

Subd. 5. **Restructured mortgage loan.** (a) The insurer shall make an evaluation of the appropriate fair value of each restructured mortgage loan. The fair value must be based upon one or more of the following procedures:

(1) an internal appraisal;

(2) an appraisal by an independent appraiser;

(3) the value of guarantees or other credit enhancements related to the loan.

(b) The insurer shall measure impairment based on the fair value of the collateral less estimated costs to obtain and sell. The difference between the adjusted fair value of the collateral and other assets received and the amortized acquisition cost of its restructured mortgage loans must be recorded as a direct write-down and a new cost basis established.

Subd. 6. **Mortgage loan in foreclosure.** (a) The insurer shall make an evaluation of the appropriate fair value of each mortgage loan in foreclosure. The fair value must be based upon an appraisal made by an independent appraiser and must be adjusted for additional expenses, such as insurance, taxes, and legal fees

that have been imposed to protect the investment or to obtain clear title to the property to the extent these amounts are expected to be recoverable from the disposition of the property.

(b) The insurer shall record as a direct write-down the difference between the fair value and the amortized acquisition cost of its mortgage loans in the process of foreclosure.

Subd. 7. **Real estate owned.** (a) The insurer shall make an evaluation of the appropriate fair value of real estate owned. The fair value must be based upon an appraisal made by an independent appraiser and must be adjusted for additional expenses, such as insurance, taxes, and legal fees that have been imposed to protect the investment or to obtain clear title to the property to the extent these amounts are expected to be recoverable from the disposition of the property.

(b) The insurer shall record as a direct write-down the difference between the fair value and the amortized acquisition cost of real estate owned.

History: *1991 c 325 art 19 s 3; 2000 c 350 s 6*

60A.124 INDEPENDENT AUDIT.

The audit report of the independent certified public accountant that performs the audit of an insurer's annual statement as required under section 60A.1291, subdivision 2, should contain a statement as to whether anything, in connection with their audit, came to their attention that caused them to believe that the insurer failed to adopt and consistently apply the valuation procedure as required by sections 60A.122 and 60A.123.

History: *1991 c 325 art 19 s 4; 1992 c 540 art 2 s 9; 1995 c 258 s 4; 2009 c 37 art 3 s 10*

60A.125 APPRAISAL BY INDEPENDENT APPRAISER.

Subdivision 1. **Mortgage loans in the process of foreclosure.** An insurer may rely upon an appraisal by an independent appraiser to determine the carrying value of mortgage loans in the process of foreclosure only if the date of the appraisal is within six months of the date the foreclosure procedure is begun. If no appraisal exists, the insurer shall acquire an appraisal within six months after the foreclosure proceeding has begun.

Subd. 2. **Real estate owned.** An insurer may rely upon an appraisal by an independent appraiser to determine the carrying value of real estate owned only if the date of the appraisal is within six months of the date when title to the property was acquired. If no appraisal exists, the insurer shall acquire an appraisal within six months after title to the property is acquired.

Subd. 3. [Repealed, 2000 c 350 s 16]

History: *1991 c 325 art 19 s 5*

60A.126 REPORTS TO BOARD; VALUATIONS.

The management of the insurer shall make periodic reports, at least annually, to its board of directors, or an appropriate committee of the board, as to the application of the insurer's valuation procedures adopted under sections 60A.121 to 60A.127.

History: *1991 c 325 art 19 s 6*

60A.127 INDEPENDENT APPRAISALS OF CERTAIN PROPERTIES.

Subdivision 1. **Random sample appraisal requirement.** Each domestic insurer that does not obtain independent appraisals of all distressed, delinquent, and restructured mortgage loans and use such appraisals to determine the carrying values for its annual statement shall obtain independent appraisals of a random sample of those loans for which it did not obtain and use such appraisals. The independent appraisals must be obtained by the insurer no later than 60 days after the filing of the insurer's annual statement. The loans to be sampled do not include loans for which the insurer determined the carrying value on the basis of guarantees or other credit enhancements.

Subd. 2. **Sampling procedure; rules.** The commissioner may adopt rules specifying the percentage of distressed, delinquent, and restructured loans for which the insurer must obtain an independent appraisal. The percentage may vary between insurers or types of loans and may apply to the number of loans, the dollar value of loans, or both. The rules may also specify a procedure for determining how to identify the specific loans for which an appraisal is required. The commissioner may adopt under this subdivision only rules that would require sampling no less extensive than that required by subdivision 3.

Subd. 3. **Statutory sampling procedure.** (a) Unless and until rules authorized by subdivision 2 are adopted, each domestic insurer must:

(1) obtain an independent appraisal of five percent of its distressed, delinquent, or restructured loans required to be sampled under subdivision 1; and

(2) establish a uniform system of assigning sequential numbers to its distressed, delinquent, or restructured loans based upon the date on which a loan first enters one of those categories, and then obtain an independent appraisal of every 20th loan required to be sampled under subdivision 1, beginning with the tenth loan or with the loan having another number that the commissioner may announce on or within five business days after the due date for filing of the annual statement.

(b) A domestic insurer may use a sampling procedure different from that described in paragraph (a) with the prior approval of the commissioner. The commissioner may grant such approval only if the different procedure would result in a sampling that is at least as accurate and as extensive under the circumstances as the method required by paragraph (a).

Subd. 4. **Record keeping; reporting.** The independent appraisals must be kept in the insurer's records and must be available to the commissioner upon request. Each insurer must file with the commissioner an annual report listing each mortgage loan for which the insurer obtained an independent appraisal under this section and showing for each of those loans the appraisal value, the carrying value determined by the insurer, and other information required by the commissioner. The report must be filed with the commissioner no later than 120 days after the filing of the annual report.

Subd. 5. **Additional requirements.** If the commissioner determines, on the basis of the report of independent appraisals required by subdivision 4, that the carrying values shown on the annual statement, determined by methods other than an independent appraisal, overstate the market value of the loans required to be sampled, the commissioner may require any of the following procedures:

(1) independent appraisals of additional loans from the loans required to be sampled;

(2) filing of a supplement to, or a revision of, the annual statement, showing revised carrying values for all or any appropriate portion of the loans required to be sampled; and

(3) a second independent appraisal for any loan for which an independent appraisal was obtained under this section.

Subd. 6. **Selection of independent appraiser.** The insurer shall not obtain more than one-third of the independent appraisals required under this section from any one appraiser or from any one firm.

Subd. 7. **Powers in this section not limiting.** This section does not limit any powers otherwise available to the commissioner.

History: *1991 c 325 art 19 s 7*

60A.128 [Repealed, 2000 c 350 s 16]

60A.1285 OTHER IMPAIRMENTS.

If distressed or delinquent mortgage loans being valued according to section 60A.123, subdivisions 3 and 4, are determined to be permanently impaired, a direct write-down must be recognized as a realized loss, and a new cost basis established.

History: *2000 c 350 s 7*

60A.129 [Repealed, 2009 c 37 art 3 s 25]

60A.1291 ANNUAL AUDIT.

Subdivision 1. **Definitions.** The definitions in this subdivision apply to this section.

(a) "Accountant" and "independent public accountant" mean an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant or firm is licensed or is required to be licensed to practice. For Canadian and British companies, the term means a Canadian-chartered or British-chartered accountant.

(b) "Affiliate" or "affiliated" means a person that directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with a person.

(c) "Audit committee" means a committee or equivalent body established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, the internal audit function of an insurer or group of insurers, if applicable, and external audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of this section at the election of the controlling person under subdivision 15, paragraph (e). If an audit committee is not designated by the insurer, the insurer's entire board of directors constitutes the audit committee.

(d) "Audited financial report" means the report described in subdivision 4.

(e) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

(f) "Independent board member" has the same meaning as described in subdivision 15, paragraph (c).

(g) "Internal audit function" means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

(h) "Internal control over financial reporting" means a process effected by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, for example, those items specified in subdivision 4, paragraphs (a), clauses (2) to (6), (b), and (c), and includes those policies and procedures that:

(1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, for example, those items specified in subdivision 4, paragraphs (a), clauses (2) to (6), (b), and (c), and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements, for example, those items specified in subdivision 4, paragraphs (a), clauses (2) to (6), (b), and (c).

(i) "SEC" means the United States Securities and Exchange Commission.

(j) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated under it.

(k) "Section 404 report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in paragraph (a).

(l) "SOX compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (section 10A(i) of the Securities Exchange Act of 1934); (ii) the audit committee independence requirements of Section 301 (section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Subd. 2. **Filing requirements.** Every insurance company doing business in this state, including fraternal benefit societies, reciprocal exchanges, service plan corporations licensed pursuant to chapter 62C, and legal service plans licensed pursuant to chapter 62G, unless exempted by the commissioner pursuant to subdivision 9, paragraph (a), or by subdivision 18, shall have an annual audit of the financial activities of the most recently completed calendar year performed by an independent certified public accountant, and shall file the report of this audit with the commissioner on or before June 1 for the immediately preceding year ending December 31. The commissioner may require an insurer to file an audited financial report earlier than June 1 with 90 days' advance notice to the insurer.

Extensions of the June 1 filing date may be granted by the commissioner for 30-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting the extension and a determination by the commissioner of good cause for the extension.

The request for extension must be submitted in writing not less than ten days before the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

If an extension is granted in accordance with this subdivision, a similar extension of 30 days is granted to the filing of management's report of internal control over financial reporting.

Every insurer required to file an annual audited financial report pursuant to this subdivision shall designate a group of individuals as constituting its audit committee. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of this subdivision at the election of the controlling person.

Subd. 3. **Exemptions.** Foreign and alien insurers filing audited financial reports in another state under the other state's requirements of audited financial reports which have been found by the commissioner to be substantially similar to these requirements are exempt from this section if a copy of the audited financial report, communication of internal control related matters noted in an audit, accountant's letter of qualifications, and report on significant deficiencies in internal controls, which are filed with the other state, are filed with the commissioner in accordance with the filing dates specified in subdivision 2 (Canadian insurers may submit accountants' reports as filed with the Canadian Dominion Department of Insurance); and a copy of any notification of adverse financial condition report filed with the other state is filed with the commissioner within the time specified in subdivision 11. Foreign or alien insurers required to file management's report of internal control over financial reporting in another state are exempt from filing the report in this state provided the other state has substantially similar reporting requirements and the report is filed with the commissioner of the other state within the time specified. This subdivision does not prohibit or in any way limit the commissioner from ordering, conducting, and performing examinations of insurers under the authority of this chapter.

Subd. 4. **Contents of annual audit; financial report.** (a) The annual audited financial report must report, in conformity with statutory accounting practices required or permitted by the commissioner of insurance of the state of domicile, the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year ended. The annual audited financial report must include:

(1) a report of an independent certified public accountant;

(2) a balance sheet reporting admitted assets, liabilities, capital, and surplus;

(3) a statement of operations;

(4) a statement of cash flows;

(5) a statement of changes in capital and surplus; and

(6) notes to the financial statements.

(b) The notes required under paragraph (a) are those required by the appropriate National Association of Insurance Commissioners (NAIC) annual statement instructions and National Association of Insurance Commissioners Accounting Practices and Procedures Manual and include reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed under section 60A.13, subdivision 1, with a written description of the nature of these differences.

(c) The financial statements included in the audited financial report must be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner. The financial statement must be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. In the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted. The amounts may be rounded to the nearest $1,000, and all immaterial amounts may be combined.

Subd. 5. **Designation of independent certified public accountant.** Each insurer required by this section to file an annual audited financial report must notify the commissioner in writing of the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit within 60 days after becoming subject to the annual audit requirement. The insurer shall obtain from the accountant a letter which states that the accountant is aware of the provisions that relate to accounting and financial matters in the insurance laws and the rules of the insurance regulatory authority of the state of domicile. The letter shall affirm that the accountant will express an opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance regulatory authority, specifying the exceptions believed to be appropriate. A copy of the accountant's letter shall be filed with the commissioner.

Subd. 6. **Report of disagreements.** If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall notify the commissioner of this event within five business days. Within ten business days of this notification, the insurer shall also furnish the commissioner with a separate letter stating whether in the 24 months preceding this event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which, if not resolved to the satisfaction of the former accountant, would have caused that person to make reference to the subject matter of the disagreement in connection with the opinion on the financial statements. The disagreements required to be reported in response to this subdivision include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this subdivision are those disagreements between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for any disagreement. The insurer shall furnish this responsive letter from the former accountant to the commissioner together with its own.

Subd. 7. **Qualifications of independent certified public accountant.** (a) The commissioner shall not recognize any person or firm as a qualified independent certified public accountant that is not in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant is licensed or is required to be licensed to practice, or for a Canadian or British company, that is not a chartered accountant, or that has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as an indemnification agreement) with respect to the audit of the insurer. Except as otherwise provided, an independent certified public accountant must be recognized as qualified as long as the person conforms to the standards of the person's profession, as contained in the Code of Professional Conduct of the American Institute of Certified Public Accountants and the Code of Professional Conduct of the Minnesota Board of Public Accountancy or similar code and the person is properly licensed in good standing with all required state boards of accountancy.

(b) The lead or coordinating audit partner, having primary responsibility for the audit, may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a

similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the commissioner for relief from this rotation requirement on the basis of unusual circumstances. This application must be made at least 30 days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

(1) number of partners, expertise of the partners, or number of insurance clients in the currently registered firm;

(2) premium volume of the insurer; or

(3) number of jurisdictions in which the insurer transacts business.

The insurer shall file, with its annual statement filing, the approval for relief from this paragraph with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(c) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following nonaudit services:

(1) bookkeeping or other services related to the accounting records or financial statements of the insurer;

(2) financial information systems design and implementation;

(3) appraisal or valuation services, fairness opinions, or contribution in-kind reports;

(4) actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if the following conditions have been met:

(i) neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(ii) the insurer has competent personnel, or engages a third-party actuary, to estimate the loss reserves for which management takes responsibility; and

(iii) the accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the loss reserves;

(5) internal audit outsourcing services;

(6) management functions or human resources;

(7) broker or dealer, investment adviser, or investment banking services;

(8) legal services or expert services unrelated to the audit; and

(9) any other services that the commissioner determines, by rule, are impermissible.

(d) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept any audited financial report, prepared in whole or in part by any natural person who has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, United States Code,

title 18, sections 1961 to 1968, or any dishonest conduct or practices under federal or state law, has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this section, or has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this section.

(e) The commissioner, after notice and hearing under chapter 14, may find that the accountant is not qualified for purposes of expressing an opinion on the financial statements in the annual audited financial report. The commissioner may require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this section.

Subd. 8. **Exemptions to qualifications of certified public accountant.** (a) Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from subdivision 7, paragraph (c). The insurer shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the commissioner finds, upon review of this statement, that compliance with this section would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

(b) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services, including tax services, that are not described in subdivision 7, paragraph (c), only if the activity is approved in advance by the audit committee, in accordance with paragraph (c).

(c) All auditing services and nonaudit services provided to an insurer by the qualified independent certified public accountant of the insurer must be preapproved by the audit committee. The preapproval requirement is waived with respect to nonaudit services if the insurer is a SOX compliant entity or a direct or indirect wholly owned subsidiary of a SOX compliant entity or:

(1) the aggregate amount of all such nonaudit services provided to the insurer constitutes not more than five percent of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the nonaudit services are provided;

(2) the services were not recognized by the insurer at the time of the engagement to be nonaudit services; and

(3) the services are promptly brought to the attention of the audit committee and approved before the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(d) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by paragraph (c). The decisions of any member to whom this authority is delegated must be presented to the full audit committee at each of its scheduled meetings.

(e) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This paragraph applies only to partners and senior managers involved in the audit. An insurer may make application to the commissioner for relief from this paragraph on the basis of unusual circumstances.

(f) The insurer shall file, with its annual statement filing, the approval for relief with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Subd. 9. **Consolidated or combined audits.** (a) The commissioner may allow an insurer to file consolidated or combined audited financial statements required by subdivision 2, in lieu of separate annual audited financial statements, where it can be demonstrated that an insurer is part of a group of insurance companies that has a pooling or 100 percent reinsurance agreement which substantially affects the solvency and integrity of the reserves of the insurer and the insurer cedes all of its direct and assumed business to the pool. An affiliated insurance company not meeting these requirements may be included in the consolidated or combined audited financial statements, if the company's total admitted assets are less than five percent of the consolidated group's total admitted assets. If these circumstances exist, then the company may file a written application to file consolidated or combined audited financial statements. This application must be for a specified period.

(b) Upon written application by a domestic insurer, the commissioner may authorize the domestic insurer to include additional affiliated insurance companies in the consolidated or combined audited financial statements. A foreign insurer must obtain the prior written authorization of the commissioner of its state of domicile in order to submit an application for authority to file consolidated or combined audited financial statements. This application must be for a specified period.

(c) A consolidated annual audit filing must include a columnar consolidated or combining worksheet. Amounts shown on the audited consolidated or combined financial statement must be shown on the worksheet. Amounts for each insurer must be stated separately. Noninsurance operations may be shown on the worksheet on a combined or individual basis. Explanations of consolidating or eliminating entries must be shown on the worksheet. A reconciliation of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statement of the insurers must be included on the worksheet.

Subd. 10. **Scope of audit and report of independent certified public accountant.** Financial statements furnished pursuant to subdivision 4 must be examined by an independent certified public accountant. The audit of the insurer's financial statements must be conducted in accordance with generally accepted auditing standards. In accordance with AICPA Statement on Auditing Standards (SAS) No. 109, Understanding the Entity and its Environment and Assessing the Risks of Material Misstatement, or its replacement, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by SAS No. 109, for those insurers required to file a management's report of internal control over financial reporting pursuant to subdivision 17, the independent certified public accountant should consider (as that term is defined in SAS No. 102, Defining Professional Requirements in Statements on Auditing Standards or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration should be given to other procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Subd. 11. **Notification of adverse financial condition.** The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to provide written notice within five business days to the board of directors of the insurer or its audit committee of any determination by that independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of sections 60A.07, 66A.32, and 66A.33 as of that date. An insurer required to file an annual audited financial report who received a notification of adverse financial

condition from the accountant shall file a copy of the notification with the commissioner within five business days of the receipt of the notification. The insurer shall provide the independent certified public accountant making the notification with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive the evidence within the required five-day period, the independent certified public accountant shall furnish to the commissioner a copy of the notification to the board of directors or its audit committee within the next five business days. No independent certified public accountant is liable in any manner to any person for any statement made in connection with this subdivision if the statement is made in good faith in compliance with this subdivision. If the accountant becomes aware of facts which might have affected the audited financial report after the date it was filed, the accountant shall take the action prescribed by AU section 561, Subsequent Discovery of Facts Existing at the Date of the Auditor's Report of the Professional Standards issued by the American Institute of Certified Public Accountants, or its replacement.

Subd. 12. **Communication of internal control related matters noted in an audit.** In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. The communication must be prepared by the accountant within 60 days after the filing of the annual audited financial report, and must contain a description of any unremediated material weakness, as the term material weakness is defined by SAS No. 115, Communicating Internal Control Related Matters Identified in an Audit, or its replacement, as of the December 31 immediately preceding so as to coincide with the audited financial report discussed in subdivision 2 in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

Subd. 13. **Accountant's letter of qualification.** The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report a letter stating that the accountant is independent with respect to the insurer and conforms to the standards of the accountant's profession as contained in the Code of Professional Conduct of the American Institute of Certified Public Accountants and the Code of Professional Conduct of the Minnesota Board of Accountancy or similar code; the background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant; that the accountant understands that the annual audited financial report and the opinion on it will be filed in compliance with this statute and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers; that the accountant consents to the requirements of subdivision 14 and that the accountant consents and agrees to make available for review by the commissioner, or the commissioner's designee or appointed agent, the work papers, as defined in subdivision 14; a representation that the accountant is properly licensed in good standing by the appropriate state licensing authorities and is a member in good standing in the American Institute of Certified Public Accountants; and a representation that the accountant complies with subdivision 7. Nothing in this section prohibits the accountant from utilizing staff the accountant deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards.

Subd. 14. **Availability and maintenance of independent certified public accountant's work papers.** Work papers are the records kept by the independent certified public accountant of the procedures followed, tests performed, information obtained, and conclusions reached pertinent to the independent certified public accountant's audit of the financial statements of an insurer. Work papers may include audit planning documents, work programs, analyses, memoranda, letters of confirmation and representation,

management letters, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of the audit of the financial statements of an insurer and that support the accountant's opinion. Every insurer required to file an audited financial report shall require the accountant, through the insurer, to make available for review by the examiners the work papers prepared in the conduct of the audit and any communications related to the audit between the accountant and the insurer. The work papers must be made available at the offices of the insurer, at the offices of the commissioner, or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the commissioner has filed a report on examination covering the period of the audit but no longer than seven years after the period reported upon, provided retention of the working papers beyond the seven years is not required by other professional or regulatory requirements. In the conduct of the periodic review by the examiners, it must be agreed that photocopies of pertinent audit work papers may be made and retained by the commissioner. These copies shall be part of the commissioner's work papers and must be given the same confidentiality as other examination work papers generated by the commissioner.

Subd. 15. **Requirements for audit committee.** (a) The audit committee must be directly responsible for the appointment, compensation, and oversight of the work of any accountant including resolution of disagreements between management and the accountant regarding financial reporting for the purpose of preparing or issuing the audited financial report or related work pursuant to this section. Each accountant shall report directly to the audit committee.

(b) The audit committee of an insurer or group of insurers is responsible for overseeing the insurer's internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by subdivision 15a.

(c) Each member of the audit committee must be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to paragraph (f) and subdivision 1, paragraph (c).

(d) In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. However, if law requires board participation by otherwise nonindependent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(e) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(f) To exercise the election of the controlling person to designate the audit committee for purposes of this section, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification must be made timely before the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the commissioner by the insurer, which shall include a description of the basis for the change. The election remains in effect for perpetuity, until rescinded.

(g) The audit committee shall require the accountant that performs for an insurer any audit required by this section to timely report to the audit committee in accordance with the requirements of SAS No. 114, The Auditor's Communication with Those Charged with Governance, or its replacement, including:

(1) all significant accounting policies and material permitted practices;

(2) all material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(3) other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(h) If an insurer is a member of an insurance holding company system, the reports required by paragraph (g) may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(i) The proportion of independent audit committee members shall meet or exceed the following criteria:

(1) for companies with prior calendar year direct written and assumed premiums $0 to $300,000,000, no minimum requirements;

(2) for companies with prior calendar year direct written and assumed premiums over $300,000,000 to $500,000,000, majority of members must be independent; and

(3) for companies with prior calendar year direct written and assumed premiums over $500,000,000, 75 percent or more must be independent.

(j) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the commissioner for a waiver from the requirements of this subdivision based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this subdivision with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

This subdivision does not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX compliant entity or a direct or indirect wholly owned subsidiary of a SOX compliant entity.

Subd. 15a. **Internal audit function requirements.** (a) An insurer is exempt from the requirements of this subdivision if:

(1) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and

(2) if the insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(b) The insurer or group of insurers shall establish an internal audit function providing independent, objective, and reasonable assurance to the audit committee and insurer management regarding the insurer's governance, risk management, and internal controls. This assurance shall be provided by performing general

and specific audits, reviews, and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(c) In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

(d) The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

(e) If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

Subd. 16. **Conduct of insurer in connection with the preparation of required reports and documents.** (a) No director or officer of an insurer shall, directly or indirectly:

(1) make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review, or communication required under this section; or

(2) omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under this section.

(b) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead, or fraudulently influence any accountant engaged in the performance of an audit pursuant to this section if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(c) For purposes of paragraph (b), actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant:

(1) to issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards;

(2) not to perform audit, review, or other procedures required by generally accepted auditing standards or other professional standards;

(3) not to withdraw an issued report; or

(4) not to communicate matters to an insurer's audit committee.

Subd. 17. **Management's report of internal control over financial reporting.** (a) Every insurer required to file an audited financial report pursuant to this section that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or group of insurers' internal control over financial

reporting, as these terms are defined in subdivision 1. The report must be filed with the commissioner along with the communication of internal control related matters noted in an audit described under subdivision 12. Management's report of internal control over financial reporting shall be as of the December 31 immediately preceding.

(b) Notwithstanding the premium threshold in paragraph (a), the commissioner may require an insurer to file management's report of internal control over financial reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition pursuant to sections 60G.20 to 60G.22.

(c) An insurer or a group of insurers that is:

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404;

(3) not directly subject to Section 404 but is a SOX compliant entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX compliant entity;

may file its or its parent's Section 404 report and an addendum in satisfaction of this requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurer's audited statutory financial statements, consisting of those items included in subdivision 4, paragraphs (a), clauses (2) to (6), (b), and (c), were included in the scope of the Section 404 report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurer's audited statutory financial statements, consisting of those items included in subdivision 4, paragraphs (a), clauses (2) to (6), (b), and (c), excluded from the Section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurer's audited statutory financial statements and those internal controls were not included in the scope of the Section 404 report, the insurer or group of insurers may either file (i) a report under this subdivision, or (ii) the Section 404 report and a report under this subdivision for those internal controls that have a material impact on the preparation of the insurer's or group of insurer's audited statutory financial statements not covered by the Section 404 report.

(d) Management's report of internal control over financial reporting shall include:

(1) a statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(2) a statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) a statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

(4) a statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of the December 31 immediately preceding. Management is not permitted to

conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting;

(6) a statement regarding the inherent limitations of internal control systems; and

(7) signatures of the chief executive officer and the chief financial officer or equivalent position or title.

(e) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in paragraph (d), are made. Management may base its assertions, in part, upon its review, monitoring, and testing of internal controls undertaken in the normal course of its activities.

(f) Management has discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation.

(g) Management's report on internal control over financial reporting, required by paragraph (a), and any documentation provided in support of the report during the course of a financial condition examination must be kept confidential by the Department of Commerce.

Subd. 18. **Exemptions.** (a) Upon written application of any insurer, the commissioner may grant an exemption from compliance with the provisions of this section. In order to receive an exemption, an insurer must demonstrate to the satisfaction of the commissioner that compliance would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for specified periods. Within ten days from the denial of an insurer's written request for an exemption, the insurer may request in writing a hearing on its application for an exemption. This hearing must be held in accordance with chapter 14. Upon written application of any insurer, the commissioner may permit an insurer to file annual audited financial reports on some basis other than a calendar year basis for a specified period. An exemption may not be granted until the insurer presents an alternative method satisfying the purposes of this section. Within ten days from a denial of a written request for an exemption, the insurer may request in writing a hearing on its application. The hearing must be held in accordance with chapter 14.

(b) This section applies to all insurers, unless otherwise indicated, required to file an annual audit by subdivision 2, except insurers having less than $1,000,000 of direct written premiums in this state in any calendar year and fewer than 1,000 policyholders or certificate holders of directly written policies nationwide at the end of the calendar year, are exempt from this section for that year, unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities, except that insurers having assumed premiums from reinsurance contracts or treaties of $1,000,000 or more are not exempt.

(c) If an insurer or group of insurers that is exempt from the subdivision 15a requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements.

Subd. 19. **Canadian and British companies.** (a) In the case of Canadian and British insurers, the annual audited financial report means the annual statement of total business on the form filed by these companies with their domiciliary supervision authority and duly audited by an independent chartered accountant.

(b) For these insurers the letter required in subdivision 5 shall state that the accountant is aware of the requirements relating to the annual audited statement filed with the commissioner under subdivision 2, and shall affirm that the opinion expressed is in conformity with those requirements.

Subd. 20. **Commercial mortgage loan valuation procedures.** A report of the independent certified public accountant that performs the audit of an insurer's annual statement as required under subdivision 2 shall be filed and contain a statement as to whether anything in connection with the audit came to the accountant's attention that caused the accountant to believe that the insurer failed to adopt and consistently apply the valuation procedures as required by sections 60A.122 and 60A.123.

Subd. 21. **Examinations.** (a) The commissioner or a designated representative shall determine the nature, scope, and frequency of examinations under this section conducted by examiners under section 60A.031. These examinations may cover all aspects of the insurer's assets, condition, affairs, and operations and may include and be supplemented by audit procedures performed by independent certified public accountants. Scheduling of examinations will take into account all relevant matters with respect to the insurer's condition, including results of the National Association of Insurance Commissioners, Insurance Regulatory Information Systems, changes in management, results of market conduct examinations, and audited financial reports. The type of examinations performed by examiners under this section must be compliance examinations, targeted examinations, and comprehensive examinations.

(b) Compliance examinations will consist of a review of the accountant's work papers defined under this section and a general review of the insurer's corporate affairs and insurance operations to determine compliance with the Minnesota insurance laws and the rules of the Department of Commerce. The examiners may perform alternative or additional examination procedures to supplement those performed by the accountant when the examiners determine that the procedures are necessary to verify the financial condition of the insurer.

(c) Targeted examinations may cover limited areas of the insurer's operations as the commissioner may deem appropriate.

(d) Comprehensive examinations will be performed when the report of the accountant as provided for in subdivision 7, paragraph (b), the notification required by subdivision 7, paragraph (c), the results of compliance or targeted examinations, or other circumstances indicate in the judgment of the commissioner or a designated representative that a complete examination of the condition and affairs of the insurer is necessary.

(e) Upon completion of each targeted, compliance, or comprehensive examination, the examiner appointed by the commissioner shall make a full and true report on the results of the examination. Each report shall include a general description of the audit procedures performed by the examiners and the procedures of the accountant that the examiners may have utilized to supplement their examination procedures and the procedures that were performed by the registered independent certified public accountant if included as a supplement to the examination.

Subd. 22. **Penalties.** An annual statement, report, or document related to the business of insurance must not be filed with the commissioner or issued to the public if it is signed by anyone who is represented in the instrument as an "accountant," unless the person is qualified as defined by this section. A violation of this subdivision is a violation of section 72A.19 and punishable in accordance with section 72A.25.

History: *2009 c 37 art 3 s 11; 2019 c 26 art 1 s 1-4*

60A.1295 ACTUARIAL OPINION OF RESERVES AND SUPPORTING DOCUMENTATION.

Subdivision 1. **Statement of actuarial opinion.** Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled "Statement of Actuarial Opinion." This opinion must be filed

in accordance with the appropriate National Association of Insurance Commissioners (NAIC) Property and Casualty Annual Statement Instructions.

Subd. 2. **Actuarial opinion summary.** (a) Every property and casualty insurance company domiciled in this state that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary, written by the company's appointed actuary. This actuarial opinion summary must be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and must be considered as a document supporting the actuarial opinion required in subdivision 1.

(b) A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

Subd. 3. **Actuarial report and workpapers.** (a) An actuarial report and its underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions must be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting actuarial report and/or workpapers at the request of the commissioner or the commissioner determines that the supporting actuarial report or workpapers provided by the insurance company are otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or workpapers.

Subd. 4. **Liability.** The appointed actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

History: *2013 c 135 art 3 s 6*

60A.1296 CONFIDENTIALITY.

Subdivision 1. **Actuarial opinion; public document.** The statement of actuarial opinion must be provided with the annual statement in accordance with the appropriate National Association of Insurance Commissioners (NAIC) Property and Casualty Annual Statement Instructions and must be treated as a public document.

Subd. 2. **Supporting materials; confidential and privileged.** (a) Documents, materials, or other information in the possession or control of the Department of Commerce that are considered an actuarial report, workpapers, or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the commissioner in connection with the actuarial report, workpapers, or actuarial opinion summary, are confidential data on individuals or protected nonpublic data as defined in section 13.02, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(b) This provision shall not be construed to limit the commissioner's authority to:

(1) release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and the ABCD establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents; or

(2) use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

Subd. 3. **Protections.** Neither the commissioner nor any person who received the documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to

testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision 2.

Subd. 4. **Exceptions.** In order to assist in the performance of the commissioner's duties, the commissioner:

(1) may share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subdivision 2 with other state, federal, and international regulatory agencies; with the NAIC and its affiliates and subsidiaries; and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality;

(2) may receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) may enter into agreements governing sharing and use of information consistent with subdivisions 2 to 4.

Subd. 5. **Nonwaiver.** No waiver of applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subdivision 4.

History: *2013 c 135 art 3 s 7*

60A.13 ANNUAL STATEMENT, INQUIRIES, RENEWAL LICENSES.

Subdivision 1. **Annual statements required.** Every insurance company, including fraternal benefit societies, and reciprocal exchanges, doing business in this state, shall file with the commissioner the appropriate verified National Association of Insurance Commissioners' annual statement blank on or before April 30 for all lines of insurance except health, which must be filed on or before May 31. The National Association of Insurance Commissioners' annual statement blank must be prepared in accordance with the association's instructions handbook and following those accounting procedures and practices prescribed by the association's accounting practices and procedures manual, unless the commissioner requires or finds another method of valuation reasonable under the circumstances. Another method of valuation permitted by the commissioner must be at least as conservative as those prescribed in the association's manual. All companies required to file an annual statement under this subdivision may also be required to file with the commissioner and the National Association of Insurance Commissioners a copy of their annual statement in an electronic form prescribed by the commissioner. All Minnesota domestic insurers required to file annual statements under this subdivision must also file quarterly statements with the commissioner for the first, second, and third calendar quarter on or before 45 days after the end of the applicable quarter, prepared in accordance with the association's instruction handbook. All companies required to file quarterly statements under this subdivision may also be required to file the quarterly statements with the commissioner and the National Association of Insurance Commissioners in an electronic form prescribed by the commissioner. In addition, the commissioner may require the filing of any other information determined to be reasonably necessary for the continual enforcement of these laws. The statement may be limited to the insurer's business and condition in the United States unless the commissioner finds that the business conducted outside the United States may detrimentally affect the interests of policyholders in this state. The statements shall also contain a verified schedule showing all details required by law for assessment and taxation. The statement

or schedules shall be in the form and shall contain all matters the commissioner may prescribe, and it may be varied as to different types of insurers so as to elicit a true exhibit of the condition of each insurer.

Subd. 1a. [Repealed, 1993 c 375 art 2 s 36]

Subd. 2. **Commissioner may inquire and require reply under oath.** The commissioner may also address to any insurer, including fraternal benefit societies, township mutuals and interinsurance exchanges, or its officers, any inquiry in relation to its transactions or conditions, or any matter connected therewith. Every insurer, or person so addressed, shall reply in writing to such inquiry promptly and truthfully, and such reply shall be verified, if required by the commissioner, by such individual or by such officer or officers of an insurer as the commissioner shall designate.

Subd. 3. [Repealed, 1978 c 793 s 98]

Subd. 3a. [Repealed, 1993 c 299 s 33]

Subd. 4. [Repealed, 1978 c 793 s 98]

Subd. 4a. [Repealed, 2007 c 13 art 2 s 3]

Subd. 5. **Renewal license.** The license issued by the commissioner is perpetual and is considered renewed annually on June 1 upon payment of the renewal license fee, the annual filing fee, and all other fees required by section 60A.14.

Subd. 6. **Company or agent cannot continue business unless statement is filed.** A company is prohibited from transacting any new business in this state after August 31 in any year unless the company previously transmitted its annual statement to the commissioner and filed a copy of its statement with the National Association of Insurance Commissioners. The commissioner may by order annually require that each insurer pay the required fee to the National Association of Insurance Commissioners for the filing of annual statements, but the fee shall not be more than 50 percent greater than the fee set by the National Association of Insurance Commissioners. Failure to file the annual statement with the commissioner or the National Association of Insurance Commissioners is a violation of section 72A.061, subdivision 1. The fee shall be based on the relative premium volume of each insurer.

Subd. 7. **Exceptions.** To file statement. No fraternal benefit society, nor any social corporation paying only sick benefits not exceeding $250 in any one year, or funeral benefits, or aiding those dependent on a member not more than $350, nor any subordinate lodge or council which is, or whose members are, assessed for benefits which are payable by a grand body, shall be required to make such statements.

Subd. 8. [Repealed, 1996 c 446 art 2 s 11]

History: *1967 c 395 art 1 s 13; 1978 c 793 s 58; 1981 c 211 s 28-31; 1984 c 592 s 7,8; 1985 c 210 art 1 s 1; 1986 c 444; 1986 c 455 s 6; 1991 c 199 art 1 s 9; 1991 c 325 art 10 s 7; 1992 c 564 art 1 s 18,54; 1993 c 299 s 4,5; 1994 c 425 s 4; 1994 c 426 s 7; 1997 c 187 art 3 s 13; 1999 c 177 s 12; 2005 c 118 s 10; 2026 c 124 art 7 s 6,7*

60A.131 OTHER BUSINESS AND INSURANCE INTERESTS, DISCLOSURE.

(a) If requested by the commissioner, an insurance company authorized to do business in this state shall disclose to the commissioner any changes in the principal management and directors of the company from that listed on page one of the annual statement within ten days of such change.

(b) Every insurance company authorized to do business in this state shall notify the commissioner within ten days after receipt of notice of any acquisition by any person, association or corporation of stock or other equity security in said insurer where such transaction, directly or indirectly, either involves five percent or more of any class of any equity security of said insurer, or such acquisition results in ownership of five percent or more of any equity security of said insurer.

(c) All principal management and directors of the company as listed on page one of its annual statement, and any person, association or corporation or any person or persons managing such company under a management contract, who are directly or indirectly the beneficial owners of more than five percent of any class of any equity security of a stock insurer or guaranty fund of a mutual insurer, shall disclose all other interests in excess of five percent which they may have in insurance agencies, other insurance companies, premium finance companies and any other companies whose principal business relates directly to the writing of insurance or the handling of claims, within 30 days following May 21, 1967. Any such interests acquired after May 21, 1967, shall be reported to the commissioner within 30 days.

History: *1967 c 609 s 1-4; 1Sp1985 c 10 s 51; 2014 c 222 art 1 s 11*

60A.135 REPORT; CERTAIN TRANSACTIONS.

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

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

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

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

History: *1995 c 214 s 7*

60A.136 ACQUISITIONS AND DISPOSITIONS OF ASSETS.

Subdivision 1. **Materiality.** No acquisitions or dispositions of assets need be reported pursuant to section 60A.135 if the acquisitions or dispositions are not material. For purposes of sections 60A.135 to 60A.137, a material acquisition (or the aggregate of any series of related acquisitions during any 30-day period) or disposition (or the aggregate of any series of related dispositions during any 30-day period) is one that is nonrecurring and not in the ordinary course of business and involves more than five percent of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the commissioner of commerce.

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

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

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

(1) date of the transaction;

(2) manner of acquisition or disposition;

(3) description of the assets involved;

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

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

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

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

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

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

History: *1995 c 214 s 8*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1995 c 214 s 9*

60A.139 ELECTRONIC NOTICES AND DOCUMENTS.

Subdivision 1. **Terms defined.** In this section, the following words have the meanings given them:

(1) "delivered by electronic means" includes:

(i) delivery to an email address at which a party has consented to receive notices or documents; or

(ii) posting on an electronic network or website accessible via the Internet, mobile application, computer, mobile device, tablet, or other electronic device, together with separate notice of posting, which must be

provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party; and

(2) "party" means a recipient of a notice or document required as part of an insurance transaction including, but not limited to, an applicant, an insured, a policyholder, or an annuity contract holder.

Subd. 2. **Requirements.** Subject to subdivision 4, a notice to a party or other document required under applicable law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means so long as it meets the requirements of the Uniform Electronic Transactions Act, chapter 325L.

Subd. 3. **Equivalent to other required methods.** Delivery of a notice or document in accordance with this section is considered equivalent to a delivery method required under applicable law, including delivery by first class mail; first class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.

Subd. 4. **Conditions for electronic delivery.** A notice or document may be delivered by electronic means by an insurer to a party under this section if:

(1) the party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(2) the party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

(i) a right or option of the party to have the notice or document provided or made available in paper or another nonelectronic form;

(ii) the right of the party to withdraw consent to have a notice or document delivered by electronic means and any fees, conditions, or consequences imposed in the event consent is withdrawn;

(iii) whether the party's consent applies:

(A) only to the particular transaction as to which the notice or document must be given; or

(B) to identified categories of notices or documents that may be delivered by electronic means during the course of the parties' relationship;

(iv)(A) the means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means; and

(B) the fee, if any, for the paper copy; and

(v) the procedure a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update information needed to contact the party electronically;

(3) the party:

(i) before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(ii) consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means to which the party has given consent; and

(4) after consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material

risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies:

(i) provides the party with a statement of:

(A) the revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means;

(B) the right of the party to withdraw consent without the imposition of a fee, condition, or consequence that was not disclosed under clause (2); and

(ii) complies with clause (2).

Subd. 5. **Content or timing not affected.** This section does not affect requirements related to content or timing of a notice or document required under applicable law.

Subd. 6. **Verification or acknowledgement of receipt.** If a provision of applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgement of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgement of receipt.

Subd. 7. **Failure to obtain consent.** The legal effectiveness, validity, or enforceability of a contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with subdivision 4, clause (3), item (ii).

Subd. 8. **Withdrawal of consent.** (a) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(b) A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(c) Failure by an insurer to comply with subdivision 4, clause (4), may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

Subd. 9. **Prior consent.** If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before August 1, 2013, and, pursuant to this section, an insurer intends to deliver additional notices or documents to the party in an electronic form then, before delivering the additional notices or documents electronically, the insurer shall notify the party of:

(1) the notices or documents that may be delivered by electronic means under this section that were not previously delivered electronically; and

(2) the party's right to withdraw consent to have notices or documents delivered by electronic means.

Subd. 10. **Property and casualty policies and endorsements.** Notwithstanding any other provisions of this section and of section 60A.08, subdivision 3, standard property and casualty insurance policies and endorsements that do not contain personally identifiable information may be mailed, delivered, or posted on the insurer's website. If the insurer elects to post insurance policies and endorsements on its website in lieu of mailing or delivering them to the insured, it must comply with all of the following conditions:

(1) the policy and endorsements must be accessible and remain that way for as long as the policy is in force;

(2) after the expiration of the policy, the insurer must archive its expired policies and endorsements for a period of five years and make them available upon request;

(3) the policies and endorsements must be posted in a manner that enables the insured to print and save the policy and endorsements using programs or applications that are widely available on the Internet and free to use;

(4) the insurer provides the following information in or simultaneously with each declarations page provided at the time of issuance of the initial policy and any renewals of that policy:

(i) a description of the exact policy and endorsement forms purchased by the insured;

(ii) a method by which the insured may obtain, upon request and without charge, a paper copy of the policy; and

(iii) the Internet address where the policy and endorsements are posted; and

(5) the insurer provides notice, in the manner it customarily communicates with an insured, of any changes to the forms or endorsements, the insured's right to obtain, upon request and without charge, a paper copy of such forms or endorsements, and the Internet address where such forms or endorsements are posted.

Subd. 11. **Oral communications.** Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may qualify as a notice or document delivered by electronic means for purposes of this section. If a provision of this title or applicable law requires a signature or notice or document to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice, or document.

Subd. 12. **Effect or other law.** This section may not be construed to modify, limit, or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act, Public Law 106-229, as amended.

Subd. 13. **Application.** This section does not apply to:

(1) a nonprofit health service plan corporation licensed under chapter 62C;

(2) a health maintenance organization licensed under chapter 62D; or

(3) a health carrier, as defined under section 62A.011, subdivision 2, that is affiliated with a nonprofit health service plan corporation licensed under chapter 62C or a health maintenance organization licensed under chapter 62D.

History: *2013 c 130 s 2*

60A.1391 CORPORATE GOVERNANCE ANNUAL DISCLOSURE.

Subdivision 1. **Scope.** (a) Nothing in this section shall be construed to prescribe or impose corporate governance standards and internal procedure beyond that which is required under applicable state corporate law. Nothing in this section shall be construed to limit the commissioner's authority, or the rights or obligations of third parties.

(b) The requirements of this section apply to all insurers domiciled in this state.

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

(b) "Commissioner" means the commissioner of commerce.

(c) "Corporate Governance Annual Disclosure (CGAD)" means a confidential report filed by the insurer or insurance group according to this section.

(d) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in section 60D.15, subdivision 5.

(e) "Insurer" has the meaning given in section 60A.705, subdivision 4, except that it does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(f) "ORSA summary report" means the report filed under section 60D.54.

(g) "Senior management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operations Officer (COO), Chief Procurement Officer (CPO), Chief Legal Officer (CLO), Chief Information Officer (CIO), Chief Technology Officer (CTO), Chief Revenue Officer (CRO), Chief Visionary Officer (CVO), or any other "C" level executive.

Subd. 3. **Disclosure and filing requirements.** (a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in subdivision 4. Notwithstanding any request from the commissioner made pursuant to paragraph (c), if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

(b) The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's or the insurance group's board of directors or the appropriate committee thereof.

(c) An insurer not required to submit a CGAD under this section shall do so upon the commissioner's request.

(d) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(e) The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in paragraph (a). If the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

(f) Insurers providing information substantially similar to the information required under this section in other documents provided to the commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to this department shall not be required to duplicate that information in the CGAD, but shall be required to clearly cross-reference the location of the relevant information within the CGAD and attach the referenced document in which the information is included if not already filed with or available to the regulator.

(g) Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

Subd. 4. **Contents of Corporate Governance Annual Disclosure.** (a) The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by this section, provided the CGAD shall contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The commissioner may request additional information deemed material and necessary to provide the commissioner with a clear understanding of the corporate governance policies, the reporting or information system, or controls implementing those policies. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

(b) The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, as these may provide a means to demonstrate the strengths of their governance framework and practices.

(c) The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:

(1) the board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current board size and structure; and

(2) the duties of the board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the board's leadership is structured, including a discussion of the roles of Chief Executive Officer and Chairman of the Board within the organization.

(d) The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(1) how the qualifications, expertise, and experience of each board member meet the needs of the insurer or insurance group;

(2) how an appropriate amount of independence is maintained on the board and its significant committees;

(3) the number of meetings held by the board and its significant committees over the past year as well as the information on director attendance;

(4) how the insurer or insurance group identifies, nominates, and elects members to the board and its committees. The discussion should include, for example:

(i) whether the nomination committee is in place to identify and select individuals for consideration;

(ii) whether term limits are placed on directors;

(iii) how the election and reelection processes function; and

(iv) whether a board diversity policy is in place and if so, how it functions; and

(5) the processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance, including any board or committee training programs that have been put in place.

(e) The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

(1) any processes or practices (i.e., sustainability standards) to determine whether officers and key persons in control functions have the appropriate background, experience, and integrity to fulfill their prospective roles, including:

(i) identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and

(ii) any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes;

(2) the insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(i) compliance with laws, rules, and regulations; and

(ii) proactive reporting of any illegal or unethical behavior;

(3) the insurer's or insurance group's processes for performance evaluation, compensation, and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the commissioner to understand how the organization ensures that compensation programs do not encourage or reward excessive risk taking. Elements to be discussed may include, for example:

(i) the board's role in overseeing management compensation programs and practices;

(ii) the various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(iii) how compensation programs are related to both company and individual performance over time;

(iv) whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(v) any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; and

(vi) any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees; and

(4) the insurer's or insurance group's plans for CEO and senior management succession.

(f) The insurer or insurance group shall describe the processes by which the board, its committees, and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

(1) how oversight and management responsibilities are delegated between the board, its committees, and senior management;

(2) how the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks; and

(3) how reporting responsibilities are organized for each critical risk area. The description should allow the commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the following critical risk areas of the insurer:

(i) risk management processes (an ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act);

(ii) actuarial function;

(iii) investment decision-making processes;

(iv) reinsurance decision-making processes;

(v) business strategy and finance decision-making processes;

(vi) compliance function;

(vii) financial reporting and internal auditing; and

(viii) market conduct decision-making processes.

Subd. 5. **Confidentiality.** (a) Documents, materials, or other information, including the CGAD, in the possession or control of the department that are obtained by, created by, or disclosed to the commissioner or any other person under this section are recognized by this state as being confidential, protected nonpublic, and containing trade secrets. Those documents, materials, or other information are classified as confidential, protected nonpublic, or both, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use the documents, materials, or other information in the furtherance of a regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other CGAD-related information pursuant to paragraph (c) below to assist in the performance of the commissioner's regular duties.

(b) Neither the commissioner nor any person who received documents, materials, or other CGAD-related information, through examination or otherwise, while acting under the authority of the commissioner, or with whom the documents, materials, or other information are shared pursuant to this section are permitted or required to testify in any private civil action concerning documents, materials, or information subject to this subdivision that are classified as confidential, protected nonpublic, or both.

(c) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(1) may, upon request, share documents, materials, or other CGAD-related information, including the confidential, protected nonpublic, and privileged documents, materials, or information subject to this subdivision including trade secret information or documents, with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in section 60D.215, with the NAIC, and with third-party consultants pursuant to subdivision 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material, or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) may receive documents, materials, or other CGAD-related information, including otherwise confidential, protected nonpublic, and privileged documents, materials, or information including trade secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in section 60D.215 and from the NAIC, and shall maintain as confidential, protected nonpublic, or privileged any documents, materials, or information received with notice or the understanding that it is confidential, protected nonpublic, or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(d) The sharing of information and documents by the commissioner pursuant to this section shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this section.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, trade-secret materials, or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the commissioner under this subdivision or as a result of sharing as authorized under this section.

Subd. 6. **NAIC and third-party consultants.** (a) The commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the CGAD and related information or the insurer's compliance with this section.

(b) Any person retained under paragraph (a) shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(c) The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the commissioner.

(d) As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this section.

(e) A written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this section shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this section:

(1) specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this section;

(2) procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(3) a provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the department and the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner;

(4) a provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this section in a permanent database after the underlying analysis is completed;

(5) a provision requiring the NAIC or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(6) a requirement that the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this section.

Subd. 7. **Sanctions.** Any insurer failing, without just cause, to timely file the CGAD as required in this section shall be required to pay a penalty of $1,000 for each day's delay, to be recovered by the commissioner and to be paid into the general fund of this state. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

History: *2019 c 26 art 4 s 1*

FEES

60A.14 FEES.

Subdivision 1. **Fees other than examination fees.** In addition to the fees and charges provided for examinations, the following fees must be paid to the commissioner for deposit in the general fund:

(a) by township mutual fire insurance companies:

(1) for filing certificate of incorporation $25 and amendments thereto, $10;

(2) for filing annual statements, $15;

(3) for each annual certificate of authority, $15;

(4) for filing bylaws $25 and amendments thereto, $10;

(b) by other domestic and foreign companies including fraternals and reciprocal exchanges:

(1) for filing an application for an initial certification of authority to be admitted to transact business in this state, $1,500;

(2) for filing certified copy of certificate of articles of incorporation, $100;

(3) for filing annual statement, $300;

(4) for filing certified copy of amendment to certificate or articles of incorporation, $100;

(5) for filing bylaws, $75 or amendments thereto, $75;

(6) for each company's certificate of authority, $750, annually;

(c) the following general fees apply:

(1) for each certificate, including certified copy of certificate of authority, renewal, valuation of life policies, corporate condition or qualification, $25;

(2) for each copy of paper on file in the commissioner's office 50 cents per page, and $2.50 for certifying the same;

(3) for license to procure insurance in unadmitted foreign companies, $575;

(4) for valuing the policies of life insurance companies, two cents per $1,000 of insurance so valued, provided that the fee shall not exceed $26,000 per year for any company. The commissioner may, in lieu of a valuation of the policies of any foreign life insurance company admitted, or applying for admission, to do business in this state, accept a certificate of valuation from the company's own actuary or from the commissioner of insurance of the state or territory in which the company is domiciled;

(5) for receiving and filing certificates of policies by the company's actuary, or by the commissioner of insurance of any other state or territory, $50;

(6) for each appointment of an agent filed with the commissioner, $30;

(7) for filing forms, rates, and compliance certifications under section 60A.315, $140 per filing, or $125 per filing when submitted via electronic filing system. Filing fees may be paid on a quarterly basis in response to an invoice. Billing and payment may be made electronically;

(8) for annual renewal of surplus lines insurer license, $400.

The commissioner shall adopt rules to define filings that are subject to a fee.

Subd. 2. **Retaliatory provisions.** When, by the laws of any other state or nation, any fines, penalties, licenses, or fees additional to, or in excess of, those imposed by this section upon foreign insurance companies and their agents, are imposed upon insurance companies of this state or their agents doing business in such state, the same fines, penalties, licenses, and fees shall be imposed upon all insurance companies of that state and their agents doing business in this state, so long as such laws of such other state remain in force. This subdivision does not apply to agent appointment fees required under subdivision 1, clause (6).

History: *1967 c 395 art 1 s 14; 1969 c 7 s 17; 1969 c 291 s 4; 1974 c 5 s 1; 1978 c 470 s 2; 1978 c 793 s 59; 1981 c 307 s 2; 1983 c 289 s 114 subd 1; 1983 c 328 s 3; 1984 c 592 s 9; 1984 c 655 art 1 s 92; 1987 c 358 s 94; 1Sp1989 c 1 art 10 s 2; 1991 c 233 s 42; 1991 c 325 art 10 s 8; 1992 c 513 art 3 s 24; 1994 c 485 s 9; 1994 c 632 art 4 s 23; 1999 c 223 art 2 s 4; 2001 c 117 art 2 s 4; 2001 c 215 s 5; 2002 c 330 s 1; 2002 c 336 s 3; 2005 c 74 s 2; 2005 c 132 s 1; 1Sp2005 c 1 art 4 s 4; 2009 c 37 art 2 s 6; 2013 c 85 art 6 s 2; 2023 c 57 art 2 s 3*

60A.15 [Repealed, 2000 c 394 art 2 s 28]

60A.151 [Repealed, 1989 c 324 s 29]

60A.152 [Repealed, 2000 c 394 art 2 s 28]

MERGERS, CONSOLIDATIONS, DOMESTICATIONS, AND CONVERSIONS

60A.16 MERGERS AND CONSOLIDATIONS.

Subdivision 1. **Scope.** (1) **Domestic insurance corporations.** Any two or more domestic insurance corporations, formed for any of the purposes for which stock, mutual, or stock and mutual insurance corporations, or reciprocal or interinsurance contract exchanges might be formed under the laws of this state, may be:

(a) merged into one of such domestic insurance corporations, or

(b) consolidated into a new insurance corporation to be formed under the laws of this state.

(2) **Domestic and foreign insurance corporations.** Any such domestic insurance corporations and any foreign insurance corporations formed to carry on any insurance business for the conduct of which an insurance corporation might be organized under the laws of this state, may be:

(a) merged into one of such domestic insurance corporations, or

(b) merged into one of such foreign insurance corporations, or

(c) consolidated into a new insurance corporation to be formed under the laws of the government under which one of such foreign insurance corporations was formed, provided that each of such foreign insurance corporations is authorized by the laws of the government under which it was formed to effect such merger or consolidation.

Subd. 2. **Procedure to be followed.** (1) **Plan of merger.** The merger or consolidation of insurance corporations can be effected only as a result of a plan of merger adopted, approved, and filed as follows:

(a) A resolution containing the plan of merger shall be approved by the affirmative vote of a majority of the directors of the board of each constituent corporation. The plan of merger shall prescribe the terms and conditions of merger or consolidation, and the mode of carrying the same into effect, with such other details and provisions as are deemed necessary. In the case of merging or consolidating stock insurance corporations or stock and mutual insurance corporations, such plan of merger may prescribe that stock of one or more of such corporations shall be converted, in whole or in part, into stock or other securities of a corporation which is not a merging or consolidating corporation or into cash.

(b) The plan of merger, or a summary of the plan approved by the commissioner, shall be submitted to the respective shareholders or members, as the case may be, of each constituent corporation, for consideration at a regular meeting or at a special meeting duly called for the purpose of considering and acting upon the plan. Written notice of the meeting, which shall state that the purpose of the meeting is to consider the proposed plan of merger, shall be given to each shareholder or member entitled to vote upon the plan of merger not less than 30 nor more than 60 days before the meeting. The plan of merger must be approved by the affirmative vote of the holders of two-thirds of the voting power of the shareholders or members present or represented at the meeting of each constituent corporation; provided, however, that in the case of a merger, except one in which any shares of the surviving insurance corporation are to be converted into shares or other securities of another corporation or into cash, the agreement need not be submitted to the shareholders

or members of that one of the insurance corporations into which it has been agreed the others shall be merged. Upon receiving the approval of the shareholders or members of each constituent corporation, articles of merger shall be prepared that contain the plan of merger and a statement that the plan has been approved by each corporation under this section.

(c) The articles of merger and plan of merger shall be delivered to the commissioner of commerce, who, if the plan of merger is reasonable and if the provisions thereof providing for any transfer of assets and assumption of liabilities are fair and equitable to the claimants and policyholders, shall issue an order approving the merger. Copies of the articles of merger, certified by the commissioner of commerce, shall be delivered to the surviving corporation or its legal representative.

(2) **Articles of incorporation of new company.** (a) If the plan of merger is for a consolidation into a new insurance corporation to be formed under any law or laws of this state, articles of incorporation for such new insurance corporation shall be prepared and delivered to the commissioner of commerce together with the articles of merger as provided in clause (1) hereof.

(b) Such articles shall be prepared, executed, approved, filed and recorded in the form and manner prescribed in, or applicable to, the particular law or laws under which the new insurance corporation is to be formed.

(3) **Abandonment.** A proposed merger or consolidation may be abandoned at any time prior to approval by the commissioner under the provision for abandonment, if any, set forth in the plan of merger.

(4) **Mutual insurance holding companies.** In the case of a merger of two mutual insurance holding companies under section 66A.40, subdivision 2, paragraph (c), the procedures set forth in subdivisions 1, 2, 3, 4, and 6 shall apply, subject to the following:

(a) the plan of merger must be fair and reasonable to the members of each constituent corporation;

(b) no member of either constituent corporation on the effective date of the merger shall lose membership solely on account of the merger;

(c) membership and voting rights in each respective constituent corporation for purposes of the meeting of the members held to consider the plan of merger shall be determined in accordance with the articles and bylaws of that constituent corporation as of a record date established in the plan of merger; and

(d) the commissioner may require changes to the plan or require certain undertakings from the surviving corporation to assure compliance with this clause.

Subd. 3. **Consummation of merger.** (1) A merger of one or more insurance corporations into a domestic insurance corporation shall be effective when the articles of merger have been approved and filed in the office of the commissioner of commerce, or at a later date specified in the articles of merger.

(2) A consolidation of insurance corporations into a new domestic insurance corporation shall be effective when the articles of merger and the new articles of incorporation have been approved and filed in the office of the commissioner of commerce, or at a later date as specified in the plan of merger.

(3) A merger or consolidation of one or more domestic insurance corporations into a foreign insurance corporation shall be effective according to the provisions of law of the jurisdiction in which the foreign insurance corporation was formed, but not until the articles of merger have been filed in accordance with subdivision 2, clause (1).

Subd. 4. **Effect of merger or consolidation.** Upon the consummation of the merger or consolidation as provided in subdivision 3, the effect of the merger or consolidation shall be:

(1) That the several corporate parties to the plan of merger shall be one insurance corporation, which shall be:

(a) in the case of a merger, that one of the constituent insurance corporations into which it has been agreed the others shall be merged and which shall survive the merger for that purpose, or

(b) in the case of a consolidation, the new insurance corporation into which it has been agreed the others shall be consolidated;

(2) The separate existence of the constituent insurance corporations shall cease, except that of the surviving insurance corporation in the case of a merger;

(3) The surviving or new insurance corporation, as the case may be, shall possess all the rights, privileges and franchises possessed by each of the former insurance corporations so merged or consolidated except that such surviving or new corporation shall not thereby acquire authority to engage in any insurance business or exercise any right which an insurance corporation may not be formed under the laws of this state to engage in or exercise;

(4) All the property, real, personal and mixed, of each of the constituent insurance corporations, and all debts due on whatever account to any of them, including without limitation subscriptions for shares, premiums on existing policies, and other choses in action belonging to any of them, shall be taken and be deemed to be transferred to and invested in such surviving or new insurance corporation, as the case may be, without further act or deed;

(5) The surviving or new insurance corporation shall be responsible for all the liabilities and obligations of each of the insurance corporations merged or consolidated, in accordance with the terms of the agreement for merger or consolidation; but the rights of the creditors of the constituent insurance corporations, or of any persons dealing with such insurance corporations shall not be impaired by such merger or consolidation, and any claim existing or action or proceeding pending by or against any of the constituent insurance corporations may be prosecuted to judgment as if the merger or consolidation had not taken place, or the surviving or new insurance corporation may be proceeded against or substituted in its place.

Subd. 5. **Nonconsenting shareholders.** (1) When an insurance corporation having capital stock has become a party to a merger or consolidation agreement, as hereinbefore provided, any shareholder of such an insurance corporation who voted against the merger or consolidation at the meeting at which it was authorized, may, at any time within 20 days after such authorization was given, object thereto in writing and demand payment for the shares held.

(2) If, after such a demand by a shareholder, the insurance corporation and the shareholder cannot agree upon the value of the shares at the time the merger or consolidation was authorized, such value shall be ascertained by three disinterested persons, one of whom shall be named by the shareholder, another by the insurance corporation and the third by the two thus chosen. The finding of the appraisers shall be final, and if their award is not paid by the insurance corporation within 30 days after it is made, it may be recovered in an action by the shareholder against the insurance corporation. The liability of the insurance corporation to the dissenting shareholder for the value of the shares so agreed upon or awarded shall also be a liability of the surviving or new insurance corporation, as the case may be. Upon payment by the insurance corporation or by the surviving or new corporation to the shareholder of the agreed or awarded price of the shares, the

shareholder shall forthwith transfer and assign the shares held at, and in accordance with, the request of the corporation.

(3) A shareholder shall not be entitled to payment for shares under the provisions of this subdivision unless the value of the corporate assets which would remain after such payment would be at least equal to the aggregate amount of its debts and liabilities including outstanding capital stock.

Subd. 6. **Disclosure of expenses; prohibitions and penalty.** All actual expenses and costs incident to proceedings under the provisions of this section shall be paid by the surviving or new company and an itemized statement of the expenses and costs shall be filed with the commissioner prior to formal approval. No officer of any such company or employee of the Department of Commerce, shall receive any compensation, gratuity or otherwise, directly or indirectly, for in any manner aiding, promoting, or assisting in such consolidation or merger.

Any officer, director, or stockholder of any company, or any employee of the state, violating, or consenting to the violation of, the provisions of this subdivision shall be punished by a fine of not less than $20,000 and by imprisonment for not less than one year.

History: *1967 c 395 art 1 s 16; 1973 c 521 s 1; 1976 c 181 s 2; 1983 c 289 s 114 subd 1; 1984 c 628 art 3 s 11; 1984 c 655 art 1 s 92; 1986 c 444; 1999 c 177 s 13-15; 2001 c 215 s 6; 2005 c 69 art 2 s 18; 2020 c 80 art 1 s 16,17*

60A.161 INSURER DOMESTICATION AND CONVERSION.

Subdivision 1. **Approval as a domestic insurer.** Any insurer that is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer of this state by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. The domestic insurer will be entitled to like certificates and licenses to transact business in this state and is subject to the authority and jurisdiction of this state.

Subd. 2. **Conversion to foreign insurer.** A domestic insurer of this state may, upon the approval of the commissioner, transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon the transfer shall cease to be a domestic insurer and shall be admitted to this state if qualified as a foreign insurer. The commissioner shall approve any proposed transfer unless the commissioner determines that the transfer is not in the interest of the policyholders of this state.

Subd. 3. **Effects.** The certificate of authority, agents appointments and licenses, rates, policy forms, and other items which the commissioner of commerce allows, in the commissioner's discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by redomestication, merger, consolidation, or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of any transferring insurer remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner. However, every transferring insurer shall notify the commissioner of the details of the proposed transfer and shall file promptly resulting amendments to corporate documents filed or required to be filed with the commissioner.

Subd. 4. **Authority to adopt rules.** The commissioner of commerce may adopt rules to carry out the purposes of this section.

History: *1990 c 424 s 1*

60A.17 Subdivision 1. [Repealed, 1992 c 564 art 3 s 30]

Subd. 1a. [Repealed, 1992 c 564 art 3 s 30]

Subd. 1b. [Repealed, 1992 c 564 art 3 s 30]

Subd. 1c. [Repealed, 1992 c 564 art 3 s 30]

Subd. 1d. [Repealed, 1992 c 564 art 3 s 30]

Subd. 2. [Repealed, 1981 c 307 s 22]

Subd. 2a. [Repealed, 1981 c 307 s 22]

Subd. 2b. [Repealed, 1981 c 307 s 22]

Subd. 2c. [Repealed, 1992 c 564 art 3 s 30]

Subd. 2d. [Repealed, 1992 c 564 art 3 s 30]

Subd. 3. [Repealed, 1992 c 564 art 3 s 30]

Subd. 4. [Repealed, 1981 c 307 s 22]

Subd. 5. [Repealed, 1992 c 564 art 3 s 30]

Subd. 5a. [Repealed, 1981 c 307 s 22]

Subd. 5b. [Repealed, 1992 c 564 art 3 s 30]

Subd. 6. [Repealed, 1992 c 564 art 3 s 30]

Subd. 6a. [Repealed, 1981 c 307 s 22]

Subd. 6b. [Repealed, 1992 c 564 art 3 s 30]

Subd. 6c. [Repealed, 1992 c 564 art 3 s 30]

Subd. 6d. [Repealed, 1992 c 564 art 3 s 30]

Subd. 7. [Repealed, 1981 c 307 s 22]

Subd. 7a. [Repealed, 1992 c 564 art 3 s 30]

Subd. 8. [Repealed, 1992 c 564 art 3 s 30]

Subd. 8a. [Repealed, 1992 c 564 art 3 s 30]

Subd. 9. [Repealed, 1981 c 307 s 22]

Subd. 9a. [Repealed, 1992 c 564 art 3 s 30]

Subd. 10. [Repealed, 1992 c 564 art 3 s 30]

Subd. 11. [Repealed, 1992 c 564 art 3 s 30]

Subd. 12. [Repealed, 1992 c 564 art 3 s 30]

Subd. 13. [Repealed, 1992 c 564 art 3 s 30]

Subd. 14. [Repealed, 1992 c 564 art 3 s 30]

Subd. 15. [Repealed, 1992 c 564 art 3 s 30]

Subd. 16. [Repealed, 1992 c 564 art 3 s 30]

Subd. 17. [Repealed, 1992 c 564 art 3 s 30]

Subd. 18. [Repealed, 1992 c 564 art 3 s 30]

Subd. 19. [Repealed, 1992 c 564 art 3 s 30]

Subd. 20. [Repealed, 1992 c 564 art 3 s 30]

Subd. 21. [Repealed, 1992 c 564 art 3 s 30]

60A.1701 [Renumbered 60K.19]

AGENCY AGREEMENTS

60A.171 REHABILITATION AND CANCELLATION OF INDEPENDENT AGENT CONTRACTS BY INSURANCE COMPANIES.

Subdivision 1. **Termination rights and obligations.** (a) After an agency contractual relationship has been in effect for a period of three years, an insurance company writing fire or casualty loss insurance in this state may not terminate the agency contractual relationship with any appointed agent unless the company has provided written notice of termination to the agent at least 60 days in advance of the effective date of the termination.

(b) The notice of termination must include the reasons for termination.

(c) An insurance company may not terminate an agency contract based upon any of the following:

(1) an adverse loss experience for a single year;

(2) the geographic location of the agent's auto and homeowners insurance business; or

(3) the performance of obligations required of an insurer under Minnesota Statutes.

(d) For purposes of this section, "fire or casualty loss insurance" means any line of insurance which an insurance agent with a personal lines, property, or casualty license under sections 60K.30 to 60K.56 may write in this state.

Subd. 2. **Agent request to renew insurance contract.** The company shall at the request of the agent renew any insurance contract written by the agent for the company for not more than one year for fire or casualty loss insurance during a period of 18 months after the effective date of the termination, but in the event any risk does not meet current underwriting standards of the company, the company may decline its renewal, provided that the company shall give the agent not less than 60 days' notice of its intention not to renew the contract of insurance. The company shall not reduce the agent's commissions, unless the company is reducing the commissions for other appointed agents in the state at the same time.

Subd. 3. **Authority to write new contract limited.** No new insurance or bond contract shall be written by the agent for the company after the effective date of the termination without the written approval of the company. The agent may increase liability on renewal or in force business for not more than one year for

the insured after the effective date of the termination if the increased liability meets the current underwriting standards of the company.

Subd. 3a. [Renumbered subd 4]

Subd. 4. MS 1990 [Renumbered subd 5]

Subd. 4. MS 2004 [Repealed, 2005 c 74 s 13]

Subd. 5. MS 1990 [Renumbered subd 6]

Subd. 5. **Earlier termination allowed.** Nothing contained in this section prohibits the earlier termination of an amendment or addendum subsequent to the inception date of the original agency agreement provided that the subsequent amendment or addendum provides for termination on shorter notice and the agent agrees in writing to the earlier termination.

Subd. 6. MS 1990 [Renumbered subd 7]

Subd. 6. **Limitation on refusal to renew business during contract term.** During the term of the contract the company shall not refuse to renew such business from the agent as would be in accordance with the company's current underwriting standards.

Subd. 7. MS 1990 [Renumbered subd 8]

Subd. 7. **Nonapplication of section.** The provisions of this section do not apply to the termination of an agent's contract for insolvency, abandonment, gross and willful misconduct, or failure to pay over to the company money due to the company after receipt by the agent of a written demand therefor, or after revocation of the agent's license by the commissioner of commerce. This section does not apply to the termination of an agent's contract if the agent is directly employed by the company or if the agent writes 80 percent or more of the agent's gross annual insurance business for one company or any or all of its subsidiaries.

Subd. 8. MS 1990 [Renumbered subd 9]

Subd. 8. **Application to contract between agent and fire and casualty loss company.** All future and presently existing agency contractual relationships between an agent and a company writing fire or casualty loss insurance in this state are subject to the provisions of this section.

Subd. 9. **Penalties.** If it is found, after notice and an opportunity to be heard as determined by the commissioner of commerce, that an insurance company has violated this section, the insurance company shall be subject to a civil action by the agent for actual damages suffered because of the premature termination of the contract by the company. The commissioner of commerce shall employ the department's investigative and enforcement authority if the commissioner has a reason to believe that an insurer has violated this section. An insurer found in violation of this section is subject to a civil penalty imposed by the commissioner not to exceed $10,000 per violation.

Subd. 10. **Compliance relief.** In the event that a company's compliance with this section is demonstrated to the satisfaction of the commissioner to represent a hazard or potential hazard to the financial integrity of the company, the commissioner may, after a hearing, issue an order relieving the company from its obligation to provide the renewal policies otherwise required by this section.

Subd. 11. **Business solicitation in notice of nonrenewal prohibited.** Upon termination of an agency, a company is prohibited from soliciting business in the notice of nonrenewal required by section 60A.37. If termination of an agency contract is the ground for nonrenewal of a policy of homeowner's insurance, as

defined in section 65A.27, subdivision 4, the company must provide notice to the policyholder that the policy is not being renewed due to the termination of the company's contract with the agency. If the agency is unable to replace the homeowner's insurance policy with a suitable policy from another insurer, the agent must notify the policyholder of the policyholder's right to renew with the company terminating the agency contract. The company must renew the policy if the insured or the insured's agent makes a written request for the renewal before the renewal date.

Subd. 12. **Cancellation of line of business as cancellation or termination of agency.** For purposes of this section, a cancellation or termination of an agent's contract is considered to have occurred if the company cancels a line of insurance business or a volume of insurance business that equals or exceeds 75 percent of the insurance business placed by that agent with the company.

History: *1977 c 287 s 1; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444; 1987 c 92 s 1-3; 1991 c 39 s 1; 1996 c 446 art 1 s 4,5; 2001 c 117 art 2 s 5; 2005 c 74 s 4,5; 2005 c 132 s 2*

60A.172 INSURANCE AGENCY CONTRACTS; CANCELLATION.

(a) An insurer may not cancel a written agreement with an agent or reduce or restrict an agent's underwriting authority with respect to property or casualty insurance, based solely on the loss ratio experience on that agent's book of business, if: the insurer required the agent to submit the application for underwriting approval, all material information on the application was fully completed, and the agent has not omitted or altered any information provided by the applicant.

(b) For purposes of this section, "loss ratio experience" means the ratio of claims paid divided by the premiums paid.

(c) This section applies only to agents who write 80 percent or more of their gross annual insurance business for one company or any or all of its subsidiaries, and are not in the direct employ of the company.

History: *1987 c 288 s 1; 1989 c 170 s 1; 1992 c 379 s 1*

60A.173 EFFECTIVE DATE.

Section 60A.172 is effective January 1, 1987, and applies to cancellations begun as of that date. As a condition of doing business in the state of Minnesota, an insurer shall promptly reinstate any agreements canceled under section 60A.172 and shall restore any authority reduced or restricted under section 60A.172 from January 1, 1987, until May 29, 1987.

History: *1987 c 288 s 2*

60A.174 SEVERABILITY.

If section 60A.173 is determined by a final, nonappealable order of any Minnesota or federal court of competent jurisdiction to be invalid or unconstitutional, section 60A.172 is effective May 29, 1987.

History: *1987 c 288 s 3*

60A.175 AGENT COMMISSIONS.

(a) An insurer that cancels a written agreement with an agent under section 60A.171 or 60A.172 or cancels a line of business sold by the agent must pay to the agent all commissions, bonuses, and other compensation earned by that agent prior to or after termination. The commission rate must be the rate in effect at the time of the notice of termination.

(b) An insurer may not reduce agent commissions, bonuses, or other compensation contained in written agreements without first providing written notice of the change to the agent at least 180 days before its effective date.

History: *1989 c 170 s 2; 1991 c 39 s 2*

60A.1755 AGENT ERRORS AND OMISSIONS INSURANCE; CHOICE OF SOURCE.

An insurance company shall not require an insurance agent to maintain insurance coverage for the agent's errors and omissions from a specific insurance company. This section does not apply if the insurance producer is a captive producer or employee of the insurance company imposing the requirement, or if that insurance company or affiliated broker-dealer pays for or contributes to the premiums for the errors and omissions coverage. For purposes of this section, "captive producer" means a producer that writes 80 percent or more of the producer's gross annual insurance business for that insurance company or any or all of its subsidiaries. Nothing in this section shall prohibit an insurance company from requiring an insurance producer to maintain errors and omissions coverage or requiring that errors and omissions coverage meet certain criteria.

History: *2009 c 178 art 1 s 6*

60A.176 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to this section and section 60A.177.

Subd. 2. [Repealed, 1991 c 207 s 8]

Subd. 3. **Agent.** "Agent" means an agent who is not an employee of the insurer, who has an agency contractual relationship that has been in effect for five or more years, and who writes 80 percent or more of the agent's business through one insurer or its subsidiaries.

Subd. 4. **Insurer.** "Insurer" means an insurance company writing property or casualty loss insurance in this state through agents.

History: *1990 c 457 s 1; 1991 c 207 s 1*

60A.177 INVOLUNTARY TERMINATION OF AN AGENT BY THE INSURER.

Subdivision 1. **Termination review process.** An insurer shall establish a termination review process for an agent involuntarily terminated by the insurer. The review process is available for use at the option of the agent. The review process must be completed within 15 days of the request or before the date of termination, whichever is later.

Subd. 2. **Notice; hearing.** If an agent is terminated by an insurer, the agent may request a hearing before the board of review. If an insurer initiates the termination of an agent's agreement, the written notice of termination must advise the agent of the agent's right to a hearing before the board of review. Upon receipt of an agent's request for a hearing, the commissioner shall establish a hearing date within 30 days of the request or longer with the approval of the agent and the insurer. The agent and the insurer shall be notified in writing of the date, time, and place of the hearing. The hearing provided for under this section is not subject to chapter 14. The review board shall provide the parties to the hearing with an opportunity to present evidence and arguments in support of their respective positions.

Subd. 3. **Board of review.** A three-member board of review shall be selected from a list of ten agents and ten insurer representatives compiled by the commissioner. One member shall be selected by the agent and one by the insurer. The third member shall be mutually agreed upon by both parties. If the parties do

not agree upon a third member, the commissioner shall request the American Arbitration Association to provide the commissioner with three names of potential members. If the American Arbitration Association declines to provide the names, the commissioner of the Bureau of Mediation Services shall provide the names. The agent member and the insurer member shall each strike one person from the list. The remaining person shall be selected as the third member of the review board. The insurer and the agent shall each pay one-half of the fee charged by the third member. The board member selected by the agent may not be a relative of the agent. The board members selected by the agent and insurer may not be presently or formerly associated with an insurer represented by the agent. An insurer is immune from civil liability to the agent for disclosures made at the hearing. This immunity does not extend to disclosures made in bad faith or with knowledge of their falseness.

Subd. 4. **Board's determination.** Upon completion of the hearing, the board of review shall determine if the termination of the agent's agreement is justified. If in the opinion of the board of review an involuntary termination is not justified, and in the absence of a reasonable contractual financial provision for termination as determined by the board, the board shall order the insurer to pay an amount of compensation that the board considers appropriate to the agent.

If in the opinion of the board of review a voluntary termination was not voluntary and the insurer is not justified in terminating the agent's agreement, and in the absence of a reasonable contractual financial provision for termination as determined by the board, the board shall order the insurer to pay an amount of compensation that the board considers appropriate to the agent.

Subd. 5. **Appeal.** A final determination of the board of review under subdivision 4 may be appealed to district court by either party for a trial de novo. If the insurer appeals and the agent prevails, the insurer is responsible for the agent's legal fees as approved by the court.

Subd. 6. **Civil penalty.** A person who intimidates or coerces a member of the board of review is subject to a civil penalty imposed by the commissioner in an amount not to exceed $25,000.

Subd. 7. **Exemption.** This section does not apply to an agent whose license has expired, is revoked, or is currently under suspension.

Subd. 8. **Administrative penalties.** Failure to comply with a final order or determination of the review board constitutes a basis for disciplinary action under section 45.027, subdivision 7.

History: *1990 c 457 s 2; 1991 c 207 s 2-5; 1992 c 379 s 2*

LIFE OR HEALTH SALES QUOTAS

60A.178 LIFE OR HEALTH INSURANCE SALES QUOTAS.

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

History: *1995 c 152 s 1*

60A.179 LIFE OR HEALTH INSURANCE SALES QUOTAS FOR EXCLUSIVE AGENTS.

Subdivision 1. **Application.** This section applies to licensed insurance agents as defined by section 60A.176.

Subd. 2. **Prohibited practice.** No insurer shall require an agent who has been licensed as an agent three years or more to sell a specified number of life or health insurance policies or a specified dollar amount of life and health insurance in relation to the sale of other insurance products. No insurer may terminate an agent's contract or reduce or restrict an agent's underwriting authority on property and casualty insurance policies based upon the sale of life or health insurance.

History: *1996 c 446 art 1 s 6*

60A.18 [Repealed, 2014 c 222 art 1 s 58]

FOREIGN COMPANIES

60A.19 FOREIGN COMPANIES.

Subdivision 1. **Requirements.** Any insurance company of another state, upon compliance with all laws governing such corporations in general and with the foregoing provisions so far as applicable and the following requirements, shall be admitted to do business in this state:

(1) It shall deposit with the commissioner a certified copy of its charter or certificate of incorporation and its bylaws, and a statement showing its financial condition and business, verified by its president and secretary or other proper officers;

(2) It shall furnish the commissioner satisfactory evidence of its legal organization and authority to transact the proposed business and that its capital, assets, deposits with the proper official of its own state, amount insured, number of risks, reserve and other securities, and guaranties for protection of policyholders, creditors, and the public, comply with those required of like domestic companies;

(3) By a duly executed instrument filed in the office of the commissioner, it shall appoint the commissioner and successors in office its lawful attorneys in fact and therein irrevocably agree that legal process in any action or proceeding against it may be served upon them with the same force and effect as if personally served upon it, so long as any of its liability exists in this state;

(4) It shall appoint, as its agents in this state, residents thereof, and obtain from the commissioner a license to transact business;

(5) Regardless of what lines of business an insurer of another state is seeking to write in this state, the lines of business it is licensed to write in its state of incorporation shall be the basis for establishing the financial requirements it must meet for admission in this state or for continuance of its authority to write business in this state;

(6) No insurer of another state shall be admitted to do business in this state for a line of business that it is not authorized to write in its state of incorporation, unless the statutes of that state prohibit all insurers from writing that line of business.

Subd. 2. **Service of garnishee process.** When garnishee process is served upon the commissioner, as attorney for any insurance company, no garnishee fee shall be paid the commissioner. After the receipt of copy of the process the insurance company may demand of the attorney of the person making the garnishee

the proper fees, and if the demand is not complied with before the day fixed for the disclosure of the garnishee, the proceeding may be dismissed.

Subd. 3. **Commissioner appointed attorney for service of process.** Before any corporation, association, or company issuing policies of insurance of any character and not organized or existing pursuant to the laws of this state is admitted to or authorized to transact the business of insurance in this state, it shall, by a duly executed instrument to be filed in the office of the commissioner, constitute and appoint the commissioner and successors in office its true and lawful attorney, upon whom proofs of loss, any notice authorized or required by any contract with the company to be served on it, summonses and all lawful processes in any action or legal proceeding against it may be served, and that the authority thereof shall continue in force irrevocable so long as any liability of the company remains outstanding in this state.

This instrument shall contain a provision and agreement declaring that the company, association, or corporation desires to transact the business of insurance in this state, and that it will accept a license therefor according to the laws of this state.

In case of the failure of any such insurance company to comply with any of the provisions of this subdivision and subdivision 4, or if it shall violate any of the conditions or agreements contained in the instrument filed, its right to transact insurance business in this state shall cease and it shall be the duty of the commissioner to immediately declare its license revoked; and, in case of revocation, the company shall not be again licensed to transact business in this state for the period of one year from date of the revocation.

Subd. 4. **Service of process.** The service of process authorized by this section shall be made in compliance with section 45.028, subdivision 2.

Subd. 5. **Provision as to alien companies.** (1) **Deposit.** Such company of any foreign country, except fraternal benefit societies, shall not be admitted until, besides complying with the foregoing requirements, it has made a deposit with the commissioner in accordance with section 60A.10, subdivision 4, or with the proper officer of some other state of the United States, of a sum not less than the deposit required of a like company by the laws of this state and this deposit shall be of the same class of securities and subject to the same limitations required for the deposit of domestic companies that must by law maintain a deposit.

This deposit shall be in exclusive trust for all its policyholders and creditors in the United States, and for all purposes of the insurance laws shall be deemed assets of the company.

(2) **Trustees, investments and funds.** Any company of a foreign country may duly appoint one or more citizens of the United States, approved by the commissioner, to hold funds or other property for the benefit of its policyholders and creditors therein. A certified copy of their appointment and of the instrument of trust shall be filed with the commissioner, who shall have the same authority in the premises as in the case of the affairs of all companies. These funds shall be invested in the same securities as required of other insurance companies and, together with the deposits required, shall constitute the assets of the company in respect to its policyholders and creditors in the United States.

Subd. 6. **Retaliatory provisions.** (1) In the event that a domestic insurance company, after complying with all reasonable laws and rulings of any other state or country, is refused permission by that state or country to transact business therein after the commissioner of commerce of Minnesota has determined that that company is solvent and properly managed and after the commissioner has so certified to the proper authority of that other state or country, then, and in every such case, the commissioner may forthwith suspend or cancel the certificate of authority of every insurance company organized under the laws of that other state or country to the extent that it insures, or seeks to insure, in this state against any of the risks or hazards which that domestic company seeks to insure against in that other state or country. Without limiting the

application of the foregoing provision, it is hereby determined that any law or ruling of any other state or country which prescribes to a Minnesota domestic insurance company the premium rate or rates for life insurance issued or to be issued outside that other state or country shall not be reasonable.

(2) This section does not apply to insurance companies organized or domiciled in a state or country, the laws of which do not impose retaliatory taxes, fines, deposits, penalties, licenses, or fees or which grant, on a reciprocal basis, exemptions from retaliatory taxes, fines, deposits, penalties, licenses, or fees to insurance companies domiciled in this state.

Subd. 7. **Policy not invalidated by occurrence of hostilities.** No policy of insurance issued to a resident of this state shall be invalidated by the occurrence of hostilities between any foreign country and the United States.

Subd. 8. MS 2010 [Renumbered, 60A.198 subd 8]

History: *1967 c 395 art 1 s 19; 1969 c 291 s 3; 1971 c 145 s 21; 1974 c 425 s 4; 1977 c 195 s 2; 1978 c 465 s 7; 1983 c 289 s 114 subd 1; 1984 c 592 s 38,39; 1984 c 609 s 3; 1984 c 655 art 1 s 92; 1986 c 444; 1Sp1989 c 1 art 10 s 4; 1991 c 291 art 9 s 2; 1992 c 511 art 7 s 2; 1992 c 564 art 1 s 54; art 2 s 3; 1994 c 485 s 10; 1994 c 632 art 4 s 24; 1999 c 177 s 16; 1999 c 243 art 7 s 1; 2000 c 394 art 2 s 4,5; 2011 c 108 s 10*

SURPLUS LINES INSURANCE

60A.195 CITATION.

Sections 60A.195 to 60A.209 shall be known and may be cited as the "Minnesota Surplus Lines Insurance Act."

History: *1981 c 221 s 1*

60A.196 DEFINITIONS.

Unless the context otherwise requires, the following terms have the meanings given them for the purposes of sections 60A.195 to 60A.209:

(a) "Affiliated group" means a group which includes the insured and any entity, or group of entities, that controls, is controlled by, or is under common control with the insured. An entity has control over another entity when: (1) the entity directly, indirectly, or acting through one or more persons owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the other entity; or (2) the entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(b) "Alien insurer" means any insurer which is incorporated or otherwise organized outside of the United States.

(c) "Association" means an association registered under section 60A.208.

(d) "Eligible surplus lines insurer" means a nonadmitted insurer recognized as eligible to write insurance business under sections 60A.195 to 60A.209.

(e) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(1) the person employs or retains a qualified risk manager to negotiate insurance coverage;

(2) the person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding 12 months;

(3) the person meets at least one of the following criteria:

(i) the person possesses a net worth in excess of $20,000,000, as such amount is adjusted pursuant to clause (4);

(ii) the person generates annual revenues in excess of $50,000,000, as such amount is adjusted pursuant to clause (4);

(iii) the person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;

(iv) the person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least $30,000,000, as such amount is adjusted pursuant to clause (4); or

(v) the person is a municipality with a population in excess of 50,000 persons.

(4) Effective January 1, 2015, and every five years thereafter, the amounts in clause (3), items (i), (ii), and (iv), shall be adjusted to reflect the percentage change for the five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.

(f) "Home state" means the state in which an insured maintains its principal place of business, or in the case of an individual, the individual's principal residence. If 100 percent of the insured risk is located out of the state, the term means the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated. If more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term means the home state of the member of the affiliated group that has the largest percentage of premium attributed to it under that insurance contract.

(g) "Ineligible surplus lines insurer" means a nonadmitted insurer not recognized as an eligible surplus lines insurer under sections 60A.195 to 60A.209.

(h) "Insurance laws" means chapters 60 to 79 inclusive.

(i) "Nonadmitted insurance" means any property and casualty insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer in this state only under sections 60A.195 to 60A.209.

(j) "Nonadmitted insurer" means an insurer not licensed to engage in the business of insurance in Minnesota, but does not include a risk retention group, as the term is defined in section 2(a)(4) of the Liability Risk Retention Act of 1986, United States Code, title 15, section 3901(a)(4).

(k) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(1) the person is an employee of, or third-party consultant retained by, the commercial policyholder;

(2) the person provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance;

(3) the person:

(i) has a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management and has three years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance;

(ii) has a designation as a Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America, an Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America, a Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education and Research, a RIMS Fellow (RF) issued by the Global Risk Management Institute, or any other designation, certification, or license determined by a state insurance commissioner or other state insurance regulatory official or entity to demonstrate minimum competency in risk management;

(iii) has at least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance and one of the designations specified in item (ii);

(iv) has at least ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

(v) has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management.

(l) "Stamping" means electronically assigning a unique identifying number that is specific to a submitted policy, contract, or insurance document.

(m) "Surplus lines broker" or "broker" means an individual, firm, or corporation which is licensed in this state to sell, solicit, or negotiate insurance on properties, risks, or exposures located or to be performed in this state with nonadmitted insurers only under sections 60A.195 to 60A.209.

History: *1981 c 221 s 2; 1987 c 337 s 11; 2008 c 366 art 17 s 1; 2011 c 108 s 11*

60A.197 RATES AND FORMS.

(a) Rates used by eligible and ineligible surplus lines insurers shall not be subject to the insurance laws except that a rate shall not be unfairly discriminatory.

(b) Forms used by eligible and ineligible surplus lines insurers pursuant to sections 60A.195 to 60A.209 shall not be subject to the insurance laws, except that a policy shall not contain language which misrepresents the true nature of the policy or class of policies.

History: *1981 c 221 s 3*

60A.198 TRANSACTION OF NONADMITTED INSURANCE.

Subdivision 1. **License required.** A person, as defined in section 60A.02, subdivision 7, shall not act in any other manner as an agent or broker in the transaction of nonadmitted insurance unless licensed under sections 60A.195 to 60A.209. A surplus lines license is not required for a licensed agent who assists in the placement of nonadmitted insurance with a surplus lines broker pursuant to sections 60A.195 to 60A.209. This subdivision does not apply to nonadmitted insurance procured by a surplus lines broker when an insured's home state is a state other than Minnesota.

Subd. 2. **Compliance with statutory provisions.** A person shall not offer, solicit, make a quotation on, sell, or issue a policy of insurance, binder, or any other evidence of insurance with a nonadmitted insurer, except in compliance with sections 60A.195 to 60A.209. This subdivision does not apply when an insured's home state is a state other than Minnesota.

Subd. 3. **Procedure for obtaining license.** A person licensed as an agent in this state pursuant to other law may obtain a surplus lines license by doing the following:

(a) filing an application in the form and with the information the commissioner may reasonably require to determine the ability of the applicant to act in accordance with sections 60A.195 to 60A.209;

(b) maintaining an agent's license in this state;

(c) registering with the association created pursuant to section 60A.2085;

(d) agreeing to file with the commissioner of revenue all returns required by chapter 297I and paying to the commissioner of revenue all amounts required under chapter 297I;

(e) agreeing to file all documents required pursuant to section 60A.2086 and to pay the stamping fee assessed pursuant to section 60A.2085, subdivision 7; and

(f) paying a fee as prescribed by section 60K.55.

Subd. 4. **Broker's powers.** A surplus lines broker may do any or all of the following:

(a) place insurance on risks in this state with eligible surplus lines insurers;

(b) place insurance on risks in this state with ineligible surplus lines insurers in strict compliance with section 60A.209. If the insurance is provided through the participation of several nonadmitted insurers and the broker has reason to believe that a substantial portion of the insurance would be assumed by eligible surplus lines insurers, then with respect to the ineligible surplus lines insurers, the insured or the insured's representative shall be informed as provided in section 60A.209, subdivision 1, clause (a); or

(c) engage in any other acts expressly or implicitly authorized by sections 60A.195 to 60A.209 and the other insurance laws.

Subd. 5. **Disclosures.** Before placement of insurance with an eligible surplus lines insurer, a surplus lines broker shall inform an insured or the insured's representative that coverage may be placed in conformance with sections 60A.195 to 60A.209 with an insurer not licensed in this state and that payment of loss is not guaranteed in the event of insolvency of the eligible surplus lines insurer.

Subd. 6. [Repealed, 2000 c 394 art 2 s 28]

Subd. 7. **Participation in national producer database for surplus lines brokers.** For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the commissioner is authorized to utilize the national insurance producer database of the National Association of Insurance Commissioners, or any other equivalent uniform national database, for the licensure of surplus lines brokers and for renewal of the licenses.

Subd. 8. **Insurance from unlicensed foreign companies.** Any person, firm, or corporation whose home state is Minnesota, that procures insurance on any property, interests, or risks of any nature other than life insurance directly from a nonadmitted insurer, must agree to file with the commissioner of revenue all returns required under chapter 297I and pay to the commissioner of revenue any amounts required to be paid under

chapter 297I. Upon that agreement, the commissioner of commerce shall issue a license, good for one year. Insurance procured under the license is valid and the provisions of the policies are considered to be in accordance, and construed as if identical in effect, with the standard policy prescribed by the laws of this state. The insurers may enter the state to perform any act necessary or proper in the conduct of the business.

History: *1981 c 221 s 4; 1983 c 328 s 7; 1984 c 592 s 40; 1986 c 444; 1987 c 337 s 12; 1989 c 260 s 6; 1990 c 480 art 6 s 2; 1993 c 375 art 10 s 4; 1994 c 632 art 4 s 25; 2000 c 394 art 2 s 6; 2001 c 12 s 1; 2001 c 117 art 2 s 6; 2009 c 178 art 1 s 7,8; 1967 c 395 art 1 s 19; 1969 c 291 s 3; 1971 c 145 s 21; 1974 c 425 s 4; 1977 c 195 s 2; 1978 c 465 s 7; 1983 c 289 s 114 subd 1; 1984 c 592 s 38,39; 1984 c 609 s 3; 1984 c 655 art 1 s 92; 1986 c 444; 1Sp1989 c 1 art 10 s 4; 1991 c 291 art 9 s 2; 1992 c 511 art 7 s 2; 1992 c 564 art 1 s 54; art 2 s 3; 1994 c 485 s 10; 1994 c 632 art 4 s 24; 1999 c 177 s 16; 1999 c 243 art 7 s 1; 2000 c 394 art 2 s 4,5; 2011 c 108 s 10,12,49*

60A.199 EXAMINATIONS.

Subdivision 1. **Examination of books and records.** If the commissioner considers it necessary, the commissioner may examine the books and records of a surplus lines broker to determine whether the broker is conducting business in accordance with sections 60A.195 to 60A.209. For the purposes of facilitating examinations, the broker shall allow the commissioner free access at reasonable times to all of the broker's books and records relating to the transactions to which sections 60A.195 to 60A.209 apply. If an examination is conducted, the cost of the examination shall be paid by the surplus line agent or agency.

Subd. 2. [Repealed, 2000 c 394 art 2 s 28]

Subd. 3. [Repealed, 2000 c 394 art 2 s 28]

Subd. 4. [Repealed, 2000 c 394 art 2 s 28]

Subd. 5. [Repealed, 2000 c 394 art 2 s 28]

Subd. 6. [Repealed, 2000 c 394 art 2 s 28]

Subd. 6a. [Repealed, 2000 c 394 art 2 s 28]

Subd. 7. [Repealed, 2000 c 394 art 2 s 28]

Subd. 8. [Repealed, 2000 c 394 art 2 s 28]

Subd. 9. [Repealed, 2000 c 394 art 2 s 28]

Subd. 10. [Repealed, 2000 c 394 art 2 s 28]

Subd. 11. [Repealed, 2000 c 394 art 2 s 28]

History: *1981 c 221 s 5; 1984 c 592 s 41; 1Sp1985 c 14 art 15 s 2; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1987 c 268 art 2 s 2-10; art 17 s 41; 1990 c 480 art 1 s 46; 1993 c 375 art 10 s 5,6; 1995 c 264 art 13 s 2,3; 2011 c 108 s 13*

60A.20 [Repealed, 1981 c 221 s 15]

60A.201 PLACEMENT OF INSURANCE BY BROKER.

Subdivision 1. **Restrictions.** Insurance shall not be placed by the surplus lines broker with a nonadmitted insurer when coverage is available from a licensed insurer.

Subd. 2. **Availability of other coverage; presumption.** There shall be a rebuttable presumption that the following coverages are available from a licensed insurer:

(1) all mandatory automobile insurance coverages required by chapter 65B;

(2) private passenger automobile physical damage coverage;

(3) homeowners and property insurance on owner-occupied dwellings whose value is less than $500,000;

(4) any coverage readily available from three or more licensed insurers unless the licensed insurers quote a premium and terms not competitive with a premium and terms quoted by an eligible surplus lines insurer; and

(5) workers' compensation insurance, except excess workers' compensation insurance which is not available from the Workers' Compensation Reinsurance Association.

Subd. 3. **Unavailability of other coverage; presumption.** There shall be a rebuttable presumption that the following coverages are unavailable from a licensed insurer:

(a) coverages where one portion of the risk is acceptable to licensed insurers but another portion of the same risk is not acceptable. The entire coverage may be placed with eligible surplus lines insurers if it can be shown that the eligible surplus lines insurer will accept the entire coverage but not the rejected portion alone; and

(b) any coverage that the broker is unable to procure after diligent search among licensed insurers.

Subd. 4. [Repealed, 2009 c 178 art 1 s 69]

Subd. 5. **Streamlined application for exempt commercial purchasers.** A surplus lines broker is not required to make a diligent search to determine whether the full amount or type of insurance can be obtained from licensed insurers when the broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser provided:

(1) the broker procuring or placing the nonadmitted insurance has disclosed to the exempt commercial purchaser that the insurance may or may not be available from a licensed insurer that may provide greater protection with more regulatory oversight; and

(2) the exempt commercial purchaser has subsequently requested in writing for the broker to procure or place the insurance from a nonadmitted insurer.

Subd. 6. **Coverage deemed unavailable.** Coverage for a risk that was referred to a surplus lines broker by a Minnesota licensed insurance producer who is not affiliated with the surplus lines broker is deemed unavailable from a licensed insurer.

Subd. 7. **FAIR plan coverage; notice.** If the insurance placed by the surplus lines broker with a nonadmitted insurer is homeowners or property insurance on an owner-occupied dwelling, the broker must print, type, or stamp in not less than ten-point type on the face of the policy the following notice: "YOU MAY BE ELIGIBLE FOR COVERAGE THROUGH THE MINNESOTA FAIR PLAN, WHICH MAKES AVAILABLE PROPERTY AND LIABILITY COVERAGE, AS DEFINED BY THE MINNESOTA FAIR PLAN ACT, TO QUALIFIED APPLICANTS WHO HAVE BEEN UNABLE TO SECURE PROPERTY AND LIABILITY INSURANCE THROUGH THE NORMAL INSURANCE MARKETS." The notice

under this subdivision must not be covered or concealed in any manner, and is in addition to the notice required under section 60A.207 or 60A.209.

History: *1981 c 221 s 6; 1992 c 564 art 1 s 21; 2009 c 178 art 1 s 9; 2011 c 108 s 14; 2024 c 114 art 1 s 1; 1Sp2025 c 4 art 3 s 1,2*

60A.202 EVIDENCE OF PLACEMENT OF INSURANCE BY BROKER.

Subdivision 1. **Restriction.** Only a surplus lines broker shall issue evidence of placement of insurance with a nonadmitted insurer.

Subd. 2. **Written communication of coverage to be delivered.** A broker shall, within seven working days after the date on which the risk was bound or the insured or applicant was advised that coverage has been or will be obtained, deliver to the insured or the insured's representative a policy, a written binder, a certificate or other written evidence of insurance placed with a nonadmitted insurer.

Subd. 3. **Contents of written communication.** The written communication showing that insurance has been obtained shall identify all known nonadmitted insurers directly assuming any risk of loss. If there is more than one nonadmitted insurer, any document issued or certified by the broker pursuant to subdivision 2 shall specify, to the extent known by the broker, whether the obligation is joint or several, and if the obligation is several, the proportion of the obligation assumed by each insurer.

History: *1981 c 221 s 7; 2011 c 108 s 15*

60A.203 RETENTION OF RECORDS.

Each surplus lines broker shall keep a separate account of each transaction entered into pursuant to sections 60A.195 to 60A.209. Evidence of these transactions shall be documented in the form and manner designated by the commissioner and retained by the broker for a minimum of five years. The forms must be readily available for review and audit by the commissioner.

History: *1981 c 221 s 8; 1992 c 564 art 1 s 22; 2011 c 108 s 16*

60A.204 FEES AND COMMISSIONS.

Subdivision 1. [Repealed by amendment, 2010 c 384 s 6]

Subd. 2. **Regulation of fees and commissions.** A surplus lines broker may charge a fee and commission, in addition to the premium, that is not excessive or discriminatory. The broker shall maintain complete documentation of all fees and commissions charged.

Subd. 3. [Repealed by amendment, 2010 c 384 s 6]

History: *1981 c 221 s 9; 2010 c 384 s 6; 2011 c 108 s 17*

60A.205 COMPENSATION.

Subdivision 1. **Authorization.** A surplus lines broker may be compensated by an eligible surplus lines insurer and the broker may compensate a licensed agent in this state for obtaining nonadmitted insurance business. A licensed agent authorized by the broker may collect a premium on behalf of the broker, and as between the insured and the broker, the broker shall be considered to have received the premium if the premium payment has been made to the agent.

Subd. 2. **Consequences of receipt.** If an eligible surplus lines insurer has assumed a risk, and if the premium for that risk has been received by the broker who placed the insurance, then as between the insurer and the insured, the insurer shall be considered to have received the premium due to it for the coverage and shall be liable to the insured for any loss covered by the insurance and for the unearned premium upon cancellation of the insurance, regardless of whether the broker is indebted to the insurer.

History: *1981 c 221 s 10; 2009 c 178 art 1 s 10; 2011 c 108 s 18,19*

60A.206 QUALIFICATION AS ELIGIBLE SURPLUS LINES INSURER.

Subdivision 1. **Insurers to be recognized by commissioner.** A surplus lines broker shall place nonadmitted insurance only with insurers which are in a stable and unimpaired financial condition. An insurer recognized by the commissioner as an eligible surplus lines insurer pursuant to subdivision 2 shall be considered to meet the requirements of this subdivision. Recognition as an eligible surplus lines insurer shall be conditioned upon the insurers continued compliance with sections 60A.195 to 60A.209.

Subd. 2. **Application for recognition.** An insurer not otherwise licensed to engage in the business of insurance in Minnesota may apply for recognition as an eligible surplus lines insurer by filing an application in the form and with the information as reasonably required by the commissioner regarding the insurer's financial stability, reputation, integrity and operating plans, accompanied by a license fee of $500. The commissioner may delegate to an association the power to process and make recommendations on applications for recognition as an eligible surplus lines insurer. Notwithstanding delegation by the commissioner, an applicant may file an application directly with the commissioner.

Subd. 3. **Standards to be met by insurers.** (a) The commissioner shall recognize the insurer as an eligible surplus lines insurer when satisfied that the insurer is in a stable, unimpaired financial condition and that the insurer is qualified to provide coverage in compliance with sections 60A.195 to 60A.209. If filed with full supporting documentation before July 1 of any year, applications submitted under subdivision 2 shall be acted upon by the commissioner before December 31 of the year of submission.

(b) The commissioner shall not authorize a foreign insurer as an eligible surplus lines insurer unless the insurer:

(1) is domiciled within a United States jurisdiction and authorized to write the type of insurance in its domiciliary jurisdiction; and

(2) has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(i) the minimum capital and surplus requirements under the laws of Minnesota; or

(ii) $15,000,000.

The requirements of item (i) may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon factors such as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $4,500,000.

(c) Eligible surplus lines insurers domiciled within the United States shall file an annual statement and an annual financial audit, under the terms and conditions of section 60A.13, subdivisions 1, 3a, and 6, and

are subject to the penalties of section 72A.061, and are subject to section 60A.03, subdivision 5, in regard to those requirements. The commissioner also has the powers provided in section 60A.13, subdivision 2, in regard to eligible surplus lines insurers.

(d) Eligible surplus lines insurers domiciled outside the United States shall file an annual statement on the standard nonadmitted insurers information office financial reporting format as prescribed by the National Association of Insurance Commissioners and an annual financial audit performed by an independent accounting firm. The commissioner shall not prohibit a surplus lines broker from placing nonadmitted insurance with, or procuring nonadmitted insurance from, an alien insurer that is included on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department.

Subd. 4. **Removal of insurers.** When the commissioner considers it necessary, the commissioner may request information about or examine the affairs of any eligible surplus lines insurer at the expense of the insurer, to determine whether the insurer should continue to remain on the list of eligible surplus lines insurers. If the commissioner determines that it is in the public interest to remove an insurer from the list because the insurer no longer meets the requirements of sections 60A.195 to 60A.209, or is no longer qualified to provide coverage under sections 60A.195 to 60A.209, the commissioner shall do so. If an insurer removed from the list desires a hearing pursuant to the Administrative Procedure Act, the hearing shall be scheduled within 30 days following request for the hearing.

Subd. 5. **Trust fund to be maintained.** Before recognition as an eligible surplus lines insurer in this state, an alien insurer shall maintain a trust fund in the United States in cash, marketable securities, or other substantially equivalent instruments of at least $1,500,000 with a United States bank which is a member of the Federal Reserve System or which is on deposit with regulatory authorities in this or another state for the benefit of all United States policyholders and beneficiaries. A trust fund required under this subdivision shall not have an expiration date which is at any time less than five years in the future, on a continuing basis.

Subd. 6. **Alternative means of compliance.** Subdivisions 3 and 5 shall not apply to a group including incorporated and unincorporated, individual alien insurers which, in place of the requirements prescribed in subdivisions 3 and 5, maintain assets as provided in subdivision 3 and hold in trust for all policyholders and beneficiaries in the United States not less than $50,000,000 in the aggregate. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and must be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members.

Subd. 7. **Appointment of agent for service of process.** Each eligible surplus lines insurer shall appoint the commissioner as its resident agent, for purposes of service of process.

History: *1981 c 221 s 11; 1986 c 444; 1987 c 358 s 95; 1992 c 564 art 1 s 23; 1994 c 426 s 8; 1994 c 485 s 11; 2011 c 108 s 20,21; 2012 c 187 art 1 s 11*

60A.207 POLICIES TO INCLUDE NOTICE.

Each policy, cover note, or instrument evidencing nonadmitted insurance from an eligible surplus lines insurer which is delivered to an insured or a representative of an insured shall have printed, typed, or stamped upon its face in not less than 10 point type, the following notice: "THIS INSURANCE IS ISSUED PURSUANT TO THE MINNESOTA SURPLUS LINES INSURANCE ACT. THE INSURER IS AN ELIGIBLE SURPLUS LINES INSURER BUT IS NOT OTHERWISE LICENSED BY THE STATE OF

MINNESOTA. IN CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED." This notice shall not be covered or concealed in any manner.

History: *1981 c 221 s 12; 2006 c 204 s 5; 2011 c 108 s 22*

60A.208 BROKER ASSOCIATION.

Subdivision 1. **Broker's right to associate.** Surplus lines brokers may associate and the commissioner may register the association for one or more of the following purposes:

(a) advising the commissioner as to the availability of nonadmitted insurance coverage and market practices and standards for nonadmitted insurers and brokers;

(b) collecting and furnishing records and statistics; or

(c) submitting recommendations regarding administration of sections 60A.195 to 60A.209.

Subd. 2. **Filing requirements.** (a) Each association shall file with the commissioner for approval all of the following:

(1) a copy of the association's constitution and articles of agreement or association, or the association's certificate of incorporation and bylaws and any rules governing the association's activities; and

(2) an agreement that, as a condition of continued registration under subdivision 1, the commissioner may examine the association.

(b) Each association shall file with the commissioner and keep current all of the following:

(1) a list of members; and

(2) the name and address of a resident of this state upon whom notices or orders of the commissioner or process issued by the commissioner may be served.

Subd. 3. **Commissioner's powers; suspension of registration.** The commissioner may refuse to register, or may suspend or revoke the registration of an association for any of the following reasons:

(a) it reasonably appears that the association will not be able to carry out the purposes of sections 60A.195 to 60A.209;

(b) the association fails to maintain and enforce rules which will assure that members of the association and persons associated with those members comply with sections 60A.195 to 60A.209, other applicable chapters of the insurance laws and rules promulgated under either;

(c) the rules of the association do not assure a fair representation of its members in the selection of directors and in the administration of its affairs;

(d) the rules of the association do not provide for an equitable allocation of reasonable dues, fees, and other charges among members;

(e) the rules of the association impose a burden on competition; or

(f) the association fails to meet other applicable requirements prescribed in sections 60A.195 to 60A.209.

Subd. 4. **Membership limited to brokers.** An association shall deny membership to any person who is not a broker.

Subd. 5. **Association is voluntary.** No broker may be compelled to join an association as a condition of receiving a license or continuing to be licensed under sections 60A.195 to 60A.209.

Subd. 6. **Financial statement to be filed.** Each association shall annually file a certified audited financial statement.

Subd. 7. **Reports and recommendations by the association.** An association may submit reports and make recommendations to the commissioner regarding the financial condition of any eligible surplus lines insurer. These reports and recommendations shall not be considered to be public information. There shall not be liability on the part of, or a cause of action of any nature shall not arise against, eligible surplus lines insurers, the association or its agents or employees, the directors, or the commissioner or authorized representatives of the commissioner, for statements made by them in any reports or recommendations made under this subdivision.

Subd. 8. **Operating assessment.** (a) Upon request from the association, the commissioner may approve the levy of an assessment of not more than one-half of one percent of premiums charged pursuant to sections 60A.195 to 60A.209 for operation of the association to the extent that the operation relieves the commissioner of duties otherwise required of the commissioner pursuant to sections 60A.195 to 60A.209. Any assessment so approved may be subtracted from the premium tax owed by the broker under chapter 297I.

(b) The association may revoke the membership and the commissioner may revoke the license in this state, of any broker who fails to pay an assessment when due, if the assessment has been approved by the commissioner.

History: *1981 c 221 s 13; 2000 c 394 art 2 s 7; 2011 c 108 s 23*

60A.2085 SURPLUS LINES ASSOCIATION OF MINNESOTA.

Subdivision 1. **Association created; duties.** There is hereby created a nonprofit association to be known as the Surplus Lines Association of Minnesota. The association is not a state agency for purposes of chapter 16A, 16B, 16C, or 43A. All surplus lines brokers are members of this association. Section 60A.208 does not apply to the association created pursuant to the provisions of this section. The association shall perform its functions under the plan of operation established under subdivision 3 and must exercise its powers through a board of directors established under subdivision 2 as set forth in the plan of operation. The association shall be authorized and have the duty to:

(1) receive, record, and stamp all nonadmitted insurance documents that surplus lines brokers are required to file with the association;

(2) prepare and deliver monthly to the commissioners of revenue and commerce a report regarding surplus lines business. The report must include a list of all the business procured during the preceding month, in the form the commissioners prescribe;

(3) educate its members regarding the surplus lines law of this state including insurance tax responsibilities and the rules and regulations of the commissioners of revenue and commerce relative to nonadmitted insurance;

(4) communicate with organizations of agents, brokers, and admitted insurers with respect to the proper use of the surplus lines market;

(5) employ and retain persons necessary to carry out the duties of the association;

(6) borrow money necessary to effect the purposes of the association and grant a security interest or mortgage in its assets, including the stamping fees charged pursuant to subdivision 7 in order to secure the repayment of any such borrowed money;

(7) enter contracts necessary to effect the purposes of the association;

(8) provide other services to its members that are incidental or related to the purposes of the association;

(9) form and organize itself as a nonprofit corporation under chapter 317A, with the powers set forth in section 317A.161 that are not otherwise limited by this section or in its articles, bylaws, or plan of operation;

(10) file such applications and take such other action as necessary to establish and maintain the association as tax exempt pursuant to the federal income tax code;

(11) recommend to the commissioner of commerce revisions to Minnesota law relating to the regulation of nonadmitted insurance in order to improve the efficiency and effectiveness of that regulation; and

(12) take other actions reasonably required to implement the provisions of this section.

Subd. 2. **Board of directors.** (a) The commissioner shall appoint an interim board of five directors within 30 days of May 30, 2008. The interim board must:

(1) establish a plan of operation within 60 days after the appointment of the interim board;

(2) create a stamping office that is operational no later than December 31, 2008; and

(3) conduct an election for a board of directors by the membership after December 31, 2008, and no later than one year after the appointment of the interim board.

(b) Once the responsibilities of the interim board in paragraph (a) are fulfilled, the association shall function through a board of directors composed of the following:

(1) one director appointed by the commissioner of revenue;

(2) one director appointed by the commissioner of commerce; and

(3) at least five but no more than seven directors elected by the members. The elected directors must be members of the association.

Directors may serve until their successors are appointed or elected and their terms are completed as outlined in the plan of operation.

Subd. 3. **Plan of operation.** (a) The plan of operation shall provide for the formation, operation, and governance of the association as a nonprofit corporation under chapter 317A. The plan of operation must provide for the election of a board of directors by the members of the association. The board of directors shall elect officers as provided for in the plan of operation. The plan of operation shall establish the manner of voting and may weigh each member's vote to reflect the annual nonadmitted insurance premium written by the member. Members employed by the same or affiliated employers may consolidate their premiums written and delegate an individual officer or partner to represent the member in the exercise of association affairs, including service on the board of directors.

(b) The plan of operation shall provide for an independent audit once each year of all the books and records of the association and a report of such independent audit shall be made to the board of directors, the

commissioner of revenue, and the commissioner of commerce, with a copy made available to each member to review at the association office.

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

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

Subd. 4. **Reporting requirement.** The association shall file with the commissioner:

(1) a copy of its plan of operation and any amendments to it;

(2) a current list of its members revised at least annually; and

(3) the name and address of a member of the board residing in this state upon whom notices or orders of the commissioner or processes issued at the direction of the commissioner may be served.

Subd. 5. **Examination.** The commissioner shall, at such times as deemed necessary, make or cause to be made an examination of the association. The officers, managers, agents, and employees of the association may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. The commissioner shall furnish a copy of the examination report to the association. If the commissioner finds the association to be in violation of this section, the commissioner may issue an order requiring the discontinuance of the violation.

Subd. 6. **Immunity.** There shall be no liability on the part of and no causes of action of any nature shall arise against the association, its directors, officers, agents, or employees for any action taken or omitted by them in the performance of their powers and duties under this section, absent gross negligence or willful misconduct.

Subd. 7. **Stamping fee.** The services performed by the association shall be funded by a stamping fee assessed for each premium-bearing document submitted to the association. The stamping fee shall be established by the board of directors of the association from time to time. The stamping fee shall be paid by the insured to the surplus lines broker and remitted to the association by the surplus lines broker in the manner established by the association.

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

History: *2008 c 366 art 17 s 2; 2009 c 178 art 1 s 11-14; 2011 c 108 s 24-27*

60A.2086 LICENSEE'S DUTY TO SUBMIT DOCUMENTS; PENALTY.

Subdivision 1. **Submission of documents to Surplus Lines Association of Minnesota; certification.** (a) A surplus lines broker shall submit every insurance policy or contract issued under the broker's license to the Surplus Lines Association of Minnesota for recording and stamping. The submission and stamping must be effected through electronic means. The submission must include:

(1) the name of the insured;

(2) a description and location of the insured property or risk;

(3) the amount insured;

(4) the gross premiums charged or returned;

(5) the name of the nonadmitted insurer from whom coverage has been procured;

(6) the kind or kinds of insurance procured; and

(7) the amount of premium subject to tax.

(b) The submission of insurance policies or contracts to the Surplus Lines Association of Minnesota constitutes a certification by the surplus lines broker, or by the insurance producer who presented the risk to the surplus lines broker for placement as a surplus lines risk, that the insurance policies or contracts were procured in accordance with sections 60A.195 to 60A.209.

Subd. 2. **Stamping requirement; penalty.** (a) It shall be unlawful for an insurance agent, broker, or surplus lines broker to deliver in this state any nonadmitted insurance policy or contract unless the insurance document is stamped by the association. A surplus lines broker's failure to comply with the requirements of this subdivision shall not affect the validity of the coverage.

(b) Any insurance agent or surplus lines broker who delivers in this state any insurance policy or contract that has not been stamped by the association shall be subject to a penalty payable to the commissioner as follows:

(1) $50 for delivery of the first unstamped policy;

(2) $250 for delivery of a second unstamped policy; and

(3) $1,000 per policy for delivery of any additional unstamped policies.

History: *2008 c 366 art 17 s 3; 2011 c 108 s 28,29*

60A.209 INSURANCE PROCURED FROM INELIGIBLE INSURERS.

Subdivision 1. **Authorization; regulation.** A resident of this state may obtain insurance from an ineligible surplus lines insurer in this state through a surplus lines broker. The broker shall first attempt to place the insurance with a licensed insurer, or if that is not possible, with an eligible surplus lines insurer. If coverage is not obtainable from a licensed insurer or an eligible surplus lines insurer, the broker shall certify to the commissioner, on a form prescribed by the commissioner, that these attempts were made. Upon obtaining coverage from an ineligible surplus lines insurer, the broker shall:

(a) Have printed, typed, or stamped in red ink upon the face of the policy in not less than 10-point type the following notice: "THIS INSURANCE IS ISSUED PURSUANT TO THE MINNESOTA SURPLUS LINES INSURANCE ACT. THIS INSURANCE IS PLACED WITH AN INSURER THAT IS NOT

LICENSED BY THE STATE NOR RECOGNIZED BY THE COMMISSIONER OF COMMERCE AS AN ELIGIBLE SURPLUS LINES INSURER. IN CASE OF ANY DISPUTE RELATIVE TO THE TERMS OR CONDITIONS OF THE POLICY OR THE PRACTICES OF THE INSURER, THE COMMISSIONER OF COMMERCE WILL NOT BE ABLE TO ASSIST IN THE DISPUTE. IN CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED." The notice may not be covered or concealed in any manner; and

(b) Collect from the insured appropriate premium taxes, as provided under chapter 297I, and report the transaction to the commissioner of revenue on a form prescribed by the commissioner. If the insured fails to pay the taxes when due, the insured shall be subject to a civil fine of not more than $3,000, plus accrued interest from the inception of the insurance.

Subd. 2. **Penalty.** Except as provided in this section, a person who assists or in any manner aids directly or indirectly in the procurement of insurance from an ineligible surplus lines insurer in this state is guilty of a misdemeanor, punishable by imprisonment for not more than 364 days, or by a fine of not more than $1,000, or both.

Subd. 3. **Duty to report.** Each insured in this state who procures, causes to be procured, or continues or renews insurance with an ineligible surplus lines insurer or any self-insurer in this state who procures or continues excess of loss, catastrophe, or other insurance upon a subject of insurance resident, located, or to be performed within this state, other than insurance procured pursuant to section 60A.201 or subdivision 1 must file with the commissioner of revenue all returns and pay to the commissioner of revenue all amounts required under chapter 297I.

Subd. 4. [Repealed, 2000 c 394 art 2 s 28]

Subd. 5. [Repealed, 2000 c 394 art 2 s 28]

Subd. 6. **Ineligible surplus lines insurers; liability on policies or contracts.** Except with respect to placement pursuant to section 60A.198, subdivision 4, if an ineligible insurer offering benefits under a written contract which constitutes the transaction of insurance or which offers benefits substantially similar to benefits under policies of insurance, whether or not the benefits are identified or described as insurance, fails to pay a claim or loss within the provision of the contract, any person who assisted or aided, directly or indirectly, in the procurement of the contract shall be liable to the person to whom the obligations are owed for the full amount of the claim or loss, in the manner provided by the contract.

History: *1981 c 221 s 14; 1983 c 289 s 114 subd 1; 1984 c 628 art 3 s 11; 1984 c 655 art 1 s 92; 1987 c 268 art 2 s 11,12; 2000 c 394 art 2 s 8; 2010 c 389 art 6 s 1; 2011 c 108 s 30; 2023 c 52 art 6 s 16*

60A.2095 CONSTRUCTION.

Nothing in sections 60A.195 to 60A.209 shall be construed to permit the state to impose requirements beyond those granted by the Liability Risk Retention Act, Public Law 99-563.

History: *1987 c 337 s 13*

UNAUTHORIZED INSURERS PROCESS

60A.21 UNAUTHORIZED INSURERS PROCESS ACT.

Subdivision 1. **Purpose.** The purpose of the Unauthorized Insurers Process Act is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts.

The legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interest the legislature herein provides a method of substituted service of process upon such insurers and declares that in so doing it exercises its power to protect its residents and to define for the purpose of this statute what constitutes doing business in this state and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, chapter 20, 1st Session, section 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

Subd. 2. **Service of process upon unauthorized insurer.** (1) Any of the following acts in this state effected by mail or otherwise by an unauthorized foreign or alien insurer: (a) the issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein; (b) the solicitation of applications for such contracts; (c) the collection of premiums, membership fees, assessments, or other considerations for such contracts; or (d) any other transaction of insurance business, is equivalent to and shall constitute an appointment by such insurer of the commissioner of commerce and the commissioner's successor or successors in office to be its true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance and any such act shall be signification of its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon such insurer.

(2) Such service of process shall be made in compliance with section 45.028, subdivision 2.

(3) Service of process in any such action, suit, or proceeding shall in addition to the manner provided in clause (2) of this subdivision be valid if served upon any person within this state who, in this state on behalf of such insurer, is: (a) soliciting insurance, or (b) making, issuing, or delivering any contract of insurance, or (c) collecting or receiving any premium, membership fee, assessment, or other consideration for insurance; and if a copy of such process is sent within ten days thereafter by certified mail by the plaintiff or plaintiff's attorney to the defendant at the last known principal place of business of the defendant and the defendant's receipt, or the receipt issued by the post office with which the letter is certified showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the administrator of the court in which such action is pending on or before the date the defendant is required to appear or within such further time as the court may allow.

(4) No plaintiff or complainant shall be entitled to a judgment by default under this subdivision until the expiration of 30 days from the date of the filing of the affidavit of compliance.

(5) Nothing in this subdivision contained shall limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner now or hereafter permitted by law.

(6) The provisions of this section shall not apply to surplus line insurance lawfully effectuated under Minnesota law, or to reinsurance, nor to any action or proceeding against an unauthorized insurer arising out of:

(a) wet marine and transportation insurance;

(b) insurance on or with respect to subjects located, resident, or to be performed wholly outside this state, or on or with respect to vehicles or aircraft owned and principally garaged outside this state;

(c) insurance on property or operations of railroads engaged in interstate commerce; or

(d) insurance on aircraft or cargo of such aircraft, or against liability, other than employer's liability, arising out of the ownership, maintenance, or use of such aircraft, where the policy or contract contains a provision designating the commissioner as its attorney for the acceptance of service of lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such policy, or where the insurer enters a general appearance in any such action.

Subd. 3. **Defense of action by unauthorized insurer.** (1) Before any unauthorized foreign or alien insurer shall file or cause to be filed any pleading in any action, suit, or proceeding instituted against it such unauthorized insurer shall: (a) Deposit with the administrator of the court in which such action, suit, or proceeding is pending cash or securities or file with such administrator a bond with good and sufficient sureties to be approved by the court in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such action; or (b) procure a certificate of authority to transact the business of insurance in this state.

(2) The court in any action, suit, or proceeding in which service is made in the manner provided in clauses (2) or (3) of subdivision 2 hereof, may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of clause (1) of this subdivision and to defend such action.

(3) Nothing in clause (1) is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in clauses (2) and (3) of subdivision 2 hereof on the ground either (a) that such unauthorized insurer has not done any of the acts enumerated in clause (1) of subdivision 2 hereof, or (b) that the person on whom service was made pursuant to clause (3) of subdivision 2 hereof, was not doing any of the acts therein enumerated.

Subd. 4. **Attorney fees and judgment.** In any action hereunder against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for 30 days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

Subd. 5. **Constitutionality.** If any provision of this section or the application thereof to any person or circumstances is held invalid such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application and to this end the provisions of this section are declared to be severable.

Subd. 6. **Citation.** This section may be cited as the "Unauthorized Insurers Process Act."

History: *1967 c 395 art 1 s 21; 1978 c 674 s 60; 1983 c 289 s 114 subd 1; 1984 c 592 s 42; 1984 c 655 art 1 s 92; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1992 c 564 art 2 s 4; 1994 c 485 s 12; 1994 c 632 art 4 s 26*

MISCELLANEOUS

60A.22 SPECIAL PROVISIONS AS TO STOCK COMPANIES; STOCKHOLDERS, OFFICERS, DIRECTORS AND INVESTORS.

Subdivision 1. **Shareholders' rights.** (1) If an insurance corporation has given notice to shareholders of a proposal to amend the articles of incorporation, which proposed amendment would substantially change the corporate purposes or would extend the duration of the corporation, a shareholder may, at any time prior to the date of the meeting at which such proposed amendment is to be voted upon, file a written objection to such amendment in the office of the secretary or president of the corporation and demand payment for shares held; provided, that such demand shall be of no force and effect if such shareholder votes in favor of the amendment, or at any time consents thereto in writing, or if the proposed amendment be not in fact effected.

(2) If, after such a demand by a shareholder, the corporation and the shareholder cannot agree upon the fair cash value of the shares at the time such amendment was authorized, such value shall be determined by three disinterested appraisers, one of whom shall be named by the shareholder, another by the corporation, and the third by the two thus chosen. The determination of a majority of the appraisers in good faith made shall be final, and if the amount so determined is not paid by the corporation within 30 days after it is made, such amount may be recovered in an action by the shareholder against the corporation. The corporation shall not be required to make payment of such amount except upon transfer to it of the shares for which such payment was demanded and upon surrender of the certificate or certificates evidencing the same.

(3) A shareholder shall not be entitled to payment for shares under the provisions of this subdivision unless the value of the corporate assets which would remain after such payment would be at least equal to the aggregate amount of its debts and liabilities exclusive of stated capital.

Subd. 2. **Transactions of principal stockholders, directors, and officers in equity securities.** (1) Every person who is directly or indirectly the beneficial owner of more than ten percent of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such company, shall file in the office of the commissioner of commerce on or before January 31, 1966, or within ten days after becoming such beneficial owner, director, or officer, a statement, in such form as the commissioner of commerce may prescribe, of the amount of all equity securities of such company of which that person is the beneficial owner, and within ten days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the commissioner of commerce a statement, in such form as the commissioner of commerce may prescribe, indicating ownership at the close of the calendar month and such changes in ownership as may have occurred during such calendar month.

(2) For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director, or officer by reason of that person's relationship to such company, any profit realized by that person from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director, or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months.

Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within 60 days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized. This clause shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the commissioner of commerce by rules may exempt as not comprehended within the purpose of this clause.

(3) It shall be unlawful for any such beneficial owner, director, or officer, directly or indirectly, to sell any equity security of such company if the person selling the security or that person's principal (a) does not own the security sold, or (b) if owning the security, does not deliver it against such sale within 20 days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this clause on proving, notwithstanding the exercise of good faith, the inability to make such delivery or deposit within such time, or without causing undue inconvenience or expense.

(4) The provisions of clause (2) shall not apply to any purchase and sale, or sale and purchase, and the provisions of clause (3) shall not apply to any sale, of any equity security of a domestic stock insurance company not then or theretofore held by the person in an investment account, by a dealer in the ordinary course of business and incident to the establishment or maintenance by the person of a primary or secondary market, otherwise than on an exchange as defined in the federal Securities Exchange Act of 1934, for such security. The commissioner of commerce may, by such rules as the commissioner deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

(5) The provisions of this subdivision shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules as the commissioner of commerce may adopt in order to carry out the purposes of this subdivision.

Subd. 3. **Regulation of proxies, consents, and authorizations.** (1) It shall be unlawful for any person, in contravention of such rules as the commissioner of commerce may prescribe as necessary or appropriate in the public interest or for the protection of investors, to solicit or to permit the use of that person's name to solicit any proxy or consent or authorization in respect of any equity security of a domestic stock insurance company.

(2) Unless proxies, consents, or authorizations in respect of an equity security of a domestic stock insurance company are solicited by or on behalf of the management of such company from the holders of record of such security in accordance with the rules prescribed under clause (1), prior to any annual or other meeting of the holders of such security, such company shall, in accordance with such rules as the commissioner of commerce may prescribe as necessary or appropriate in the public interest or for the protection of investors, if required thereby, file with the commissioner of commerce and transmit to all holders of record of such security information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

Subd. 4. **Securities excepted.** The provisions of subdivisions 2 and 3 hereof shall not apply to equity securities of a domestic stock insurance company if (a) any equity security of such company shall be registered, or shall be required to be registered, pursuant to section 12 of the federal Securities Exchange Act of 1934, or if (b) such company shall not have equity securities held of record by 100 or more persons

on the last day of the year next preceding the year in which the provisions of subdivisions 2 and 3 hereof would apply except for the provisions of this clause (b).

Subd. 5. **Rules.** The commissioner of commerce shall have the power to make such rules as may be necessary for the execution of the functions vested in the commissioner by subdivisions 2 and 3 hereof, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within the commissioner's jurisdiction. No provision of subdivisions 2 and 3 hereof imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule of the commissioner of commerce, notwithstanding that such rule may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

Subd. 6. **Definitions.** (1) The term "equity security" when used in this section means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the commissioner of commerce shall deem to be of similar nature and consider necessary or appropriate, by such rules as the commissioner may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(2) The term "domestic stock insurance company" when used in this section includes a domestic stock and mutual insurance company as defined in sections 66A.36 to 66A.43.

History: *1967 c 395 art 1 s 22; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1985 c 248 s 70; 1986 c 444; 2005 c 69 art 2 s 18*

60A.23 MISCELLANEOUS.

Subdivision 1. **Liability of directors and officers generally.** If a company be at any time under liability for losses exceeding its net assets, and the president and directors, or any of them, knowing it, directly or indirectly, issue or consent to the issue of further insurance, each shall be personally liable for any loss under this insurance; and if any of them insures or allows to be insured on a single risk a larger sum than is authorized by law, that person shall be personally liable for any loss thereon above the amount which might lawfully be insured.

Subd. 2. **Liability of directors and officers of mutual company.** No director or other officer of any mutual company shall, officially or privately, guarantee a policyholder thereof against an assessment to which the policyholder would otherwise be liable. When the directors of any mutual company fail for 30 days after entry of any judgment, or for six months after the accruing of any other indebtedness against it, to levy and deliver for collection any assessment required by law for payment thereof, or to apply the proceeds thereof in either case, each shall be personally liable for the amount thereof, and for all debts and claims then outstanding or which may accrue until the assessment shall be levied and put in process of collection. When the treasurer unreasonably fails to collect and properly apply the proceeds of any such assessment the treasurer shall be personally liable, not exceeding the total assessment, to any person entitled thereto, and shall be repaid only out of funds thereafter collected thereon.

Subd. 3. **Conflict of interest and compensation in mutual fire company.** No officer or other person employed to determine the character of a risk, and decide the question of its acceptance by any mutual fire company other than a town or farmers company, shall receive a commission or other payment therefrom, but that person's compensation shall be by fixed salary and such share, if any, of the net profits as the directors may determine; and such officer or person shall not be an employee of any other officer or agent of the company, nor interested in the officer's or agent's business.

Subd. 4. **Dividends; limitations.** Domestic stock companies shall follow the dividend limitation and reporting requirements set forth in chapter 60D.

Subd. 5. **Provisions as to fidelity and surety companies.** (1) **Requirements and acceptability.** No company for guaranteeing the fidelity of persons in fiduciary positions, public or private, or for acting as surety, shall transact any business in this state until it shall have satisfied the commissioner that it has complied with all the provisions of law and obtained the commissioner's certificate to that effect. Thereupon it shall be authorized to execute as sole or joint surety any bond, undertaking, or recognizance which, by any municipal or other law, or by the rules or regulations of any municipal or other board, body, organization, or officer, is required or permitted to be made, given, tendered, or filed for the security or protection of any person, corporation, or municipality, or any department thereof, or of any other organization, conditioned for the doing or omitting of anything in such bond or other instrument specified or provided; and any and all courts, judges, officers, and heads of departments, boards, and municipalities required or permitted to accept or approve of the sufficiency of any such bond or instrument may in their discretion accept the same when executed, or the conditions thereof guaranteed solely or jointly by any such company, and the same shall be in all respects full compliance with every law or other provisions for the execution or guaranty by one surety or by two or more sureties, or that sureties shall be residents or householders, or landowners, or all or either.

(2) **Limits of risk.** No fidelity or surety company shall insure or reinsure in a single risk, less any portion thereof reinsured, a larger sum than one-tenth of its net assets.

Subd. 6. **Company's principal place of business to be designated.** When a company establishes any agency in a place other than that of its principal place of business, all signs, cards, pamphlets, or other printed matter issued shall designate such principal place.

Subd. 7. [Repealed, 1989 c 330 s 37]

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

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

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

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

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

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

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

(3) **License.** No vendor of risk management services or entity administering a self-insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license may be granted only when the commissioner is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner may issue a license subject to restrictions or limitations upon the authorization, including the type of services which may be supplied or the activities which may be engaged in. The license fee is $1,500 for the initial application and $1,500 for each three-year renewal. All licenses are for a period of three years.

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

No contract entered into after July 1, 2001, between a licensed vendor of risk management services and a group authorized to self-insure for workers' compensation liabilities under section 79A.03, subdivision 6, may take effect until it has been filed with the commissioner, and either (1) the commissioner has approved it or (2) 60 days have elapsed and the commissioner has not disapproved it as misleading or violative of public policy.

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

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

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

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

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

History: *1967 c 395 art 1 s 23; Ex1967 c 1 s 6; 1969 c 497 s 1; 1975 c 145 s 1; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1978 c 465 s 8; 1980 c 528 s 1; 1Sp1981 c 4 art 2 s 44,45; 1982 c 424 s 130; 1983 c 154 s 1; 1983 c 289 s 114 subd 1; 1983 c 328 s 8; 1984 c 592 s 43; 1984 c 655 art 1 s 92; 1986 c 444; 1987 c 337 s 14; 1987 c 358 s 96; 1990 c 422 s 10; 1992 c 564 art 4 s 4; 1993 c 299 s 6; 1994 c 425 s 5; 1995 c 233 art 2 s 56; 1995 c 258 s 5; 1997 c 200 art 1 s 41; 1999 c 223 art 2 s 5; 2001 c 215 s 7; 2004 c 228 art 2 s 1; 2005 c 132 s 3; 2009 c 178 art 1 s 15*

STOP LOSS CONTRACTS

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

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

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

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

(b) "Direct coverage" means coverage under which an insurance company or health carrier assumes a direct obligation to an individual, under the policy or evidence of coverage, with respect to health care expenses incurred by the individual or a member of the individual's family.

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

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

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

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

Subd. 3. **Health plan policies issued as stop loss coverage.** (a) An insurance company or health carrier issuing or renewing an insurance policy or other evidence of coverage, that provides coverage to an employer

for health care expenses incurred under an employer-sponsored plan provided to the employer's employees, retired employees, or their dependents, shall issue the policy or evidence of coverage as a health plan if the policy or evidence of coverage:

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

(2) has an aggregate attachment point that is lower than 110 percent of expected claims.

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

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

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

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

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

History: *1995 c 258 s 6; 2009 c 178 art 1 s 16; 2017 c 2 art 2 s 2*

60A.236 STOP LOSS REGULATION; SMALL EMPLOYER COVERAGE.

A contract providing stop loss coverage, issued or renewed to a small employer, as defined in section 62L.02, subdivision 26, or to a plan sponsored by a small employer, must include a claim settlement period no less favorable to the small employer or plan than the following:

(1) claims incurred during the contract period; and

(2) paid by the plan during the contract period or within three months after expiration of the contract period.

History: *1995 c 258 s 7; 2017 c 2 art 2 s 3*

EXEMPTION FOR FRATERNALS

60A.24 EXEMPTIONS FROM INSURANCE LAWS OF THIS STATE.

The following are exempt from all insurance laws of the state: All organizations listed in section 64B.38 of the laws relating to fraternal benefit societies.

History: *1967 c 395 art 1 s 24; 1985 c 49 s 41; 1992 c 564 art 1 s 54*

INSOLVENCY, SUSPENSION, AND DISCIPLINE OF INSURERS

60A.25 INSOLVENT COMPANIES.

Subdivision 1. **Notification of policyholders.** Whenever any foreign or domestic insurance company authorized to transact the business of insurance in Minnesota is adjudicated insolvent, or whenever its policies are declared null and void by court order, the commissioner of commerce shall ascertain the names and last known addresses of all Minnesota policyholders of said company, and shall notify all Minnesota policyholders within 30 days of such adjudication or court order. In the case of foreign insurers authorized to do business in this state, the commissioner of commerce may elect to notify all of the company's licensed agents in Minnesota with a directive that the agents notify all insureds of the company's insolvency or that its policies have been declared null and void.

Subd. 2. **Remittance of premiums.** Every agency contract written by an insurance company writing property and casualty insurance in Minnesota shall contain or be construed to contain the following provision: "Notwithstanding any other provision of this contract, the obligation of the agent to remit written premiums to the company shall be changed upon the commencement of any administrative or legal proceeding by any state against the carrier regarding its financial condition. After the commencement of the proceedings, the obligation of the agent to remit premiums shall be confined to the premiums earned before the commencement of the proceedings. The agent shall not owe or remit to the company or to the liquidator or receiver any premiums that are unearned as of the date of the commencement of the delinquency proceedings, and any unearned premiums in the possession of the agent on the date shall be returned promptly by the agent to the insured or, with the approval of the insured, be used to purchase new coverage for the insured with a different insurer."

History: *1967 c 368 s 1; 1971 c 527 s 1; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 455 s 7*

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

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

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

History: *1967 c 369 s 1; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444; 1995 c 258 s 8*

60A.27 DISCIPLINE OF INSURER BY ANOTHER STATE; NOTICE TO COMMISSIONER.

Subdivision 1. **Requirement.** An insurance company licensed to transact business in this state is hereby required to notify the commissioner of commerce within ten business days of the happening of any one or more of the following:

(1) the suspension or revocation of its right to transact business in another state; or

(2) the receipt by the insurance company of an order to show why its license should not be suspended or revoked.

Subd. 2. **Penalty.** Any insurance company which fails to notify the commissioner of commerce within the time period specified in subdivision 1 is subject to a penalty of not more than $500, or suspension, or both.

History: *1967 c 448 s 1,2; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1991 c 325 art 21 s 1; 2017 c 98 s 3*

DOCUMENTS FILED WITH COMMISSIONER

60A.28 DOCUMENTS FILED WITH COMMISSIONER, VERIFICATION.

The commissioner of commerce may require that any document required by law to be filed with the commissioner, be accompanied by a sworn verification of its contents by a responsible officer of the corporation filing it. The commissioner shall prescribe the form of the verification by rule.

History: *1967 c 457 s 1; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444*

NONPROFIT RISK INDEMNIFICATION

60A.29 NONPROFIT RISK INDEMNIFICATION TRUST ACT.

Subdivision 1. **Title.** This section may be cited as the "Nonprofit Risk Indemnification Trust Act."

Subd. 2. **Purpose.** The purpose of this section is to authorize the establishment of trust funds for the purpose of indemnifying nonprofit beneficiary organizations and their officers, directors, and agents for financial loss due to the imposition of legal liability or for damage or destruction of property, and to regulate the operation of trust funds established under this section.

Subd. 3. **Approval of commissioner.** No trust fund with the purpose of indemnifying multiple nonprofit beneficiary organizations shall be established without the prior approval of the commissioner of the Department of Commerce. The commissioner shall withhold approval of any trust fund that fails to comply with the provisions and requirements of this section.

Subd. 4. **Eligible beneficiaries.** No organization, corporation, agency, or program shall be a beneficiary of any trust fund established under this section unless it is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1954, as amended through December 30, 1985. No trust fund established under this section shall agree to indemnify the state of Minnesota, any political subdivision of the state, or any hospital licensed pursuant to section 144.55. No trust fund established under this section shall indemnify any beneficiary for loss or damage to property permanently located outside the boundaries of this state or for legal liabilities arising from operations or activities occurring outside this state, except where those operations or activities are of a nonroutine nature; provided, however, that this restriction shall not apply to

a beneficiary which is incorporated under the laws of this state and has its principal office located in this state.

Subd. 5. **Ineligible risks.** No trust fund established under this section shall indemnify any beneficiary for liabilities incurred under the Workers' Compensation Act, or for benefits provided to employees pursuant to any medical, dental, life, or disability income protection plan.

Subd. 6. **Benefit schedules.** Every trust fund established under this section shall establish in its bylaws or plan of operation a schedule of benefits, to be approved by the commissioner, governing the indemnification of beneficiaries of the trust. The schedule of benefits shall include all conditions, limitations, and exclusions relevant to indemnification.

Subd. 7. **Indemnification agreements.** Every trust fund established under this section shall provide each of its beneficiaries with a written indemnification agreement specifying the rights and obligations of the trust fund and the beneficiary under the agreement. Each form of indemnification agreement shall be filed with and approved by the commissioner.

Subd. 8. **Contributions.** The trust fund shall establish contributions required of beneficiaries necessary to fund the operations of the fund. All contribution schedules shall be filed with and approved by the commissioner prior to use. Contributions must be based on sound actuarial principles and be adequate to fund the operation of the trust fund. Contributions may not be excessive, in relation to the benefits provided, or unfairly discriminatory.

Subd. 9. **Risk pooling or sharing agreements prohibited.** No trust fund established under this section shall enter into an agreement with any other trust fund whereby the risks assumed by each are pooled or shared.

Subd. 10. **Board of trustees.** Every trust fund established under this section shall be governed by a board of no fewer than five trustees. The initial trustees need not be appointed or elected by the beneficiaries of the trust fund. During the second year following the creation of an authorized trust fund, at least one-fourth of all its trustees in office shall have been elected or appointed by the beneficiaries. After the end of the second year following the creation of an authorized trust fund, a majority of all trustees in office shall have been elected or appointed by the beneficiaries. All trustees serving during the first two years following the creation of an authorized trust fund shall be elected or appointed for one-year terms. All trustees serving thereafter shall be elected or appointed for two-year terms, provided that the trustees may be elected or appointed for one-year terms to the extent necessary in order to create staggered terms. Any trustee may be removed at any time, with or without cause, by a majority vote of the beneficiaries. The board of trustees shall meet no fewer than four times each year.

Subd. 11. **Trustees; compensation.** No trustee shall be paid a salary or receive other compensation for service as a trustee, except that the bylaws or plan of operation may provide for reimbursement for actual expenses incurred on behalf of the trust fund and for the payment of a reasonable per diem amount for attendance at meetings of the board.

Subd. 12. **Bylaws; plan of operation.** The trustees of each trust fund authorized under this section shall cause to be adopted a set of bylaws or plan of operation which shall govern the operation of the trust fund. All bylaws or plans of operation or amendments to them are subject to prior approval by the commissioner. The commissioner shall adopt rules governing the content and approval of bylaws or plans of operation.

Subd. 13. **Financial statement; report on operations.** Every trust fund authorized under this section shall, by June 1 of every year, file with the commissioner a financial statement for the previous year's

operations. The financial statement must include the opinion of a certified public accountant that the statement was prepared in conformity with generally accepted accounting principles. Also by June 1 of every year, every trust fund must file with the commissioner, on forms provided by the department, a report summarizing the trust fund's operations during the previous year.

Subd. 14. **Financial standards.** Every authorized trust fund shall have and maintain financial assets sufficient to satisfy all current and future financial obligations and responsibilities to beneficiaries. The commissioner shall adopt rules establishing minimum financial standards for authorized trust funds.

Subd. 15. **Contracts; fees.** Authorized trust funds may enter into contracts with risk management service providers, actuarial consultants, or other vendors as are necessary to ensure the effective and efficient operation of the trust fund. Fees paid to vendors for services provided must not be excessive.

Subd. 16. **Reinsurance.** Authorized trust funds may insure or reinsure their obligations and liabilities with:

(1) insurance companies authorized to do business in Minnesota, pursuant to section 60A.06;

(2) insurance companies similarly authorized in any other state of the United States;

(3) insurance companies not authorized in Minnesota or any other state if the unauthorized insurance company establishes reinsurance security in favor of the ceding trust fund conforming to the general rules for allowance of reinsurance credits stated in the Financial Condition Examiners Handbook adopted by the National Association of Insurance Commissioners; or

(4) other trust funds organized under this section or under similar laws of any other state if the reinsuring trust fund establishes reinsurance security as specified in clause (3) in favor of the ceding trust fund.

Subd. 17. **Interbeneficiary cause of action.** No beneficiary shall have any cause of action against any other beneficiary arising solely out of the insolvency or inability of the trust fund to meet its obligations.

Subd. 18. **Examination.** The commissioner may examine authorized trust funds to the same extent and with the same purpose as is provided, with respect to insurance companies, by section 60A.031.

Subd. 19. **Security deposit.** As a condition of authorization, every trust fund shall deposit with the commissioner an acceptable security of a value equal to not less than $500,000. In the event that a trust fund fails to honor the obligations assumed by it under trust agreements issued to its beneficiaries, use of the security deposit shall revert to the commissioner for the purpose of executing the trust fund's obligations to its beneficiaries. The commissioner shall adopt rules governing the amount of security required and the acceptable forms of security.

Subd. 20. **Rules.** The commissioner may adopt rules to enforce and administer the requirements of this section.

Subd. 21. **Trust funds not subject to insurance rules.** Trust funds established under this section shall not be considered insurance companies or to be in the business of insurance nor shall they be subject to regulation by the commissioner, except as provided for in this section.

Subd. 22. **Foreign trust funds.** A trust fund organized and existing under the laws of another state for the sole purpose of indemnifying nonprofit beneficiary organizations and their officers, directors, and agents for financial loss due to the imposition of legal liability or for damage or destruction of property, as provided in subdivisions 2 and 4, may apply to the commissioner for authority to operate within this state, provided that:

(1) the trust fund has been continuously in operation for a period of not less than five years prior to the date it applies for authorization under this subdivision, during which period it must have issued only nonassessable indemnification agreements to its beneficiaries, and during each of those years the trust fund received not less than $1,000,000 in contributions from beneficiaries for protections afforded by the trust fund;

(2) the trust fund has been authorized by and is subject to regulation and examination by the department of insurance of its domiciliary state;

(3) the trust fund must file with the commissioner its trust agreement, bylaws or plan of operation, schedule of benefits, forms of indemnification agreements, and contribution schedules applicable to beneficiaries in this state;

(4) the trust fund must be governed by a board of not fewer than five trustees, all of whom must be elected by the beneficiaries of the trust fund, and none of whom may receive compensation for service as a trustee;

(5) the trust fund has, as of the last day of the calendar year immediately prior to its application for authority, a net fund balance surplus of not less than $1,000,000, as evidenced by its financial statements certified by an independent certified public accountant in accordance with generally accepted accounting principles consistently applied; and

(6) the trust fund must, upon and at all times after authorization by the commissioner, maintain a registered office within this state.

Subd. 23. **Standards for authorization.** Within 60 days after receipt of the documents specified under subdivision 22 and supporting evidence which establishes compliance with the standards set forth under that subdivision, the commissioner shall grant to the trust fund a certificate of authority to conduct operations in this state. The operations in this state are subject to the limitations and standards set forth in subdivisions 4 to 22. In the event an authorized foreign trust fund violates one of those subdivisions or the rules of the commissioner applicable to foreign trust funds, the commissioner may suspend or revoke the certificate of authority.

Subd. 24. **Rules.** The commissioner may adopt rules to enforce and administer requirements of subdivisions 22 and 23.

History: *1985 c 248 s 70; 1986 c 455 s 8; 1987 c 337 s 15-20*

60A.30 [Renumbered 60A.351]

60A.31 [Renumbered 60A.352]

EXPEDITED FORM AND RATE FILING

60A.315 EXPEDITED FORM AND RATE FILING.

Subdivision 1. **Authority.** An insurer or rate service organization otherwise required to file rates and forms may use the expedited filing procedure under this section for homeowner's insurance as defined in section 65A.27, subdivision 4, and automobile insurance as governed by chapter 65B.

Subd. 2. **Compliance certifications.** An insurer or rate service organization shall file with the Department of Commerce on a prescribed form a description of the policy, amendment, or endorsement and a written

certification signed by an officer of the insurer or the rate service organization that the forms, policies, amendments, and endorsements comply with all applicable Minnesota statutes, rules, and case law, and a copy of the policy, amendment, or endorsement. If the filing will impact rates, the filing must comply with section 70A.06, subdivisions 1 and 1a. Forms and rates filed under this procedure are effective upon receipt by the department. Anyone using the expedited filing procedures authorized by this section must provide copies of the form filings within 24 hours of receiving a request from the commissioner. Insurers may comply with this requirement by providing the form filings in paper or electronic format.

Subd. 3. **Application of law.** If an insurer uses the services of a rate service organization for purposes of filing a certificate of compliance under this section, the certification by the rate service organization under subdivision 2 does not excuse the insurer from its obligation to ensure that its filing complies with all applicable Minnesota statutes, rules, and case law.

Subd. 4. **Fees.** In order to be effective, the filing must be accompanied by payment of the filing fee applicable to the policy, amendment, endorsement, or rate unless the fee is remitted in accordance with an alternative procedure allowed under section 60A.14.

Subd. 5. **Record keeping.** The insurer or rate service organization shall retain the policy, amendment, or endorsement for at least five years after that policy, amendment, or endorsement ceased providing coverage to any Minnesota policyholder, and shall provide to the Department of Commerce upon request a copy of any form in use pursuant to these filing procedures.

Subd. 6. **Audits; penalties.** The commissioner is authorized to conduct audits and investigations under section 45.027 and this chapter to determine if the insurers are complying with Minnesota law in the issuance of policies described under this section. If the policy filings contain provisions that are inconsistent with or violate Minnesota law, the commissioner may take action against the insurer under section 45.027. The commissioner shall assess the insurer for the costs of the investigation performed by the department and shall deposit all such assessments into the revolving fund established under section 60A.03.

History: *2005 c 74 s 3*

CROP HAIL INSURANCE RATE FILING

60A.32 RATE FILING FOR CROP HAIL INSURANCE.

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

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

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

History: *1988 c 688 art 9 s 1; 1995 c 24 s 1; 1999 c 177 s 17; 2009 c 178 art 1 s 17*

CANCELLATION AND RENEWAL OF COMMERCIAL LIABILITY AND/OR PROPERTY POLICIES

60A.35 SCOPE.

Except as specifically limited in section 60A.351, sections 60A.35 to 60A.38 apply to all commercial liability and/or property insurance policies issued by companies licensed to do business in this state except ocean marine insurance, accident and health insurance, excess insurance, surplus lines insurance, and reinsurance.

History: *1987 c 337 s 23; 1994 c 485 s 65*

60A.351 RENEWAL OF INSURANCE POLICY WITH ALTERED RATES.

If an insurance company licensed to do business in this state offers or purports to offer to renew any commercial liability and/or property insurance policy at less favorable terms as to the dollar amount of coverage or deductibles, higher rates, and/or higher rating plan, the new terms, the new rates and/or rating plan may take effect on the renewal date of the policy if the insurer has sent to the policyholder notice of the new terms, new rates and/or rating plan at least 30 days prior to the expiration date. If the insurer has not so notified the policyholder, the policyholder may elect to cancel the renewal policy within the 60-day period after receipt of the notice. Earned premium for the period of coverage, if any, shall be calculated pro rata upon the prior rate. This section does not apply to ocean marine insurance, accident and health insurance, reinsurance, and coverage under the federal Terrorism Risk Insurance Act.

This section does not apply if the change relates to guide "a" rates or excess rates also known as "consent to rates" or if there has been any change in the risk insured.

History: *1986 c 455 s 58; 1987 c 337 s 21; 1994 c 485 s 65; 2002 c 330 s 2; 2005 c 74 s 6; 2007 c 104 s 1*

60A.352 WORKERS' COMPENSATION INSURANCE.

In addition to the requirements of Minnesota Statutes 1984, section 176.185, subdivision 1, a policy of insurance issued to cover the liability to pay compensation under Minnesota Statutes 1984, chapter 176, shall comply with sections 60A.35 to 60A.38.

History: *1986 c 455 s 59; 1987 c 337 s 22; 1994 c 485 s 65*

60A.36 MIDTERM CANCELLATION.

Subdivision 1. **Reason for cancellation.** No insurer may cancel a policy of commercial liability and/or property insurance during the term of the policy, except for one or more of the following reasons:

(1) nonpayment of premium;

(2) misrepresentation or fraud made by or with the knowledge of the insured in obtaining the policy or in pursuing a claim under the policy;

(3) actions by the insured that have substantially increased or substantially changed the risk insured;

(4) refusal of the insured to eliminate known conditions that increase the potential for loss after notification by the insurer that the condition must be removed;

(5) substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the contract;

(6) loss of reinsurance by the insurer which provided coverage to the insurer for a significant amount of the underlying risk insured. A notice of cancellation under this clause shall advise the policyholder that the policyholder has ten days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within 30 business days after receipt of the appeal;

(7) a determination by the commissioner that the continuation of the policy could place the insurer in violation of the insurance laws of this state; or

(8) nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to obtaining or continuing the insurance. This provision for cancellation for failure to pay dues does not apply to persons who are retired at 62 years of age or older or who are disabled according to Social Security standards.

Subd. 2. **Notice.** Cancellation under subdivision 1, clauses (2) to (8), shall not be effective before 60 days after notice to the policyholder. The notice of cancellation shall contain a specific reason for cancellation as provided in subdivision 1.

A policy shall not be canceled for nonpayment of premium pursuant to subdivision 1, clause (1), unless the insurer, at least ten days before the effective cancellation date, has given notice to the policyholder of the amount of premium due and the due date. The notice shall state the effect of nonpayment by the due date. No cancellation for nonpayment of premium shall be effective if payment of the amount due is made before the effective date in the notice.

Subd. 2a. **Third-party notices.** An insurer shall provide notice to a third party if:

(1) the policyholder has, separately from the certificate, notified the insurer of the identity of the third party; and

(2) the third party is a licensing authority authorized by statute to receive the notice or a state, city, or county governmental unit on whose behalf the insured is providing services.

Subd. 3. **New policies.** Subdivisions 1 and 2 do not apply to any insurance policy that has not been previously renewed if the policy has been in effect less than 90 days at the time the notice of cancellation is mailed or delivered. No cancellation under this subdivision is effective until at least ten days after the written notice to the policyholder.

Subd. 4. **Longer-term policies.** A policy may be issued for a term longer than one year or for an indefinite term with a clause providing for cancellation by the insurer for the reasons stated in subdivision 1 by giving notice as required by subdivision 2 at least 60 days before any anniversary date.

Subd. 5. **Rescission.** (a) No insurer may rescind or void a contract of liability or property insurance unless there was material misrepresentation, material omission, or fraud made by or with the knowledge of the insured in obtaining the contract or in pursuing a claim under the policy.

(b) No misrepresentation or omission shall be material unless knowledge by the insurer of the facts misrepresented or omitted would have led to a refusal by the insurer to make such a contract. In determining the question of materiality, evidence of the practice of the insurer with respect to the acceptance or rejection of similar risks shall be admissible.

(c) For purposes of this section, a representation is a statement as to past or present fact, made to an insurer or the insurer's agent by the applicant as an inducement for issuing a contract of commercial liability or property insurance. A misrepresentation is a false representation, and the facts misrepresented are those facts which make the representation false.

(d) This subdivision does not limit the right to cancel the policy prospectively for the reasons stated in subdivision 1, clause (2).

History: *1987 c 337 s 24; 1994 c 485 s 13; 1996 c 446 art 1 s 7; 2010 c 384 s 7*

60A.37 NONRENEWAL.

Subdivision 1. **Notice required.** At least 60 days before the date of expiration provided in the policy, a notice of intention not to renew the policy beyond the agreed expiration date must be made to the policyholder by the insurer. If the notice is not given at least 60 days before the date of expiration provided in the policy, the policy shall continue in force until 60 days after a notice of intent not to renew is received by the policyholder.

Subd. 2. **Exceptions.** This section does not apply if the policyholder has insured elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal.

History: *1987 c 337 s 25*

60A.38 INTERPRETATION AND PENALTIES.

Subdivision 1. **Sections not exclusive.** Sections 60A.35 to 60A.38 are not exclusive, and the commissioner may also consider other provisions of Minnesota law to be applicable to the circumstances or situations addressed by sections 60A.35 to 60A.38. The rights provided by sections 60A.35 to 60A.38 are in addition to and do not prejudice any other rights the policyholder may have at common law, under statute, or rules.

Subd. 2. **Penalties.** A violation of any provisions of sections 60A.35 to 60A.38 shall be deemed to be an unfair trade practice in the business of insurance and shall subject the violator to the penalties provided by sections 72A.17 to 72A.32 in addition to any other penalty provided by law.

Subd. 3. **Notices required.** All notices required by sections 60A.35 to 60A.38 shall only be made by first class mail addressed to the policyholder's last known address or by delivery to the policyholder's last known address. Notice by first class mail is effective upon deposit in the United States mail. In addition to giving notice to the policyholder, the insurer must also give notice to the agent of record, if any, in the manner specified for the policyholder.

Subd. 4. **Proof of mailing notice.** Unless otherwise specifically required, United States Postal Service proof of mailing of the notice of cancellation, reduction in the limits of liability of coverage, or nonrenewal of an insurance policy is sufficient proof the proper notice has been given.

History: *1987 c 337 s 26; 1990 c 475 s 1*

CERTIFICATES OF INSURANCE

60A.39 CERTIFICATES OF INSURANCE.

Subdivision 1. **Issuance.** A licensed insurer or insurance producer may provide to a third party a certificate of insurance which documents insurance coverage. For the purposes of this chapter, a certificate of insurance

is a document that provides evidence of property or liability insurance coverage and the amount of insurance issued, and does not convey any contractual rights to the certificate holder.

Subd. 2. **Approval.** An insurer or licensed producer shall not issue a certificate of insurance or other document or instrument that either affirmatively or negatively amends, extends, or alters the coverage provided by an approved policy, form, or endorsement without the written approval of the commissioner.

Subd. 3. **Required statement.** A certificate or memorandum of property or casualty insurance when issued to any person other than the policyholder must contain the following or similar statement: "This certificate or memorandum of insurance does not affirmatively or negatively amend, extend, or alter the coverage afforded by the insurance policy."

Subd. 4. **Cancellation notice.** A certificate provided to a third party must not provide for notice of cancellation that exceeds the statutory notice of cancellation provided to the policyholder or a period of notice specified in the policy.

Subd. 5. **Filing.** An insurer not using the standard ACORD or ISO form "Certificate of Insurance" shall file with the commissioner, prior to its use, a similar alternative "Certificate of Insurance" covering the same information for use by the insurer. Filed forms may not be amended at the request of a third party.

Subd. 6. **Opinion letters.** A licensed insurance producer may not issue, in lieu of a certificate, an agent's opinion letter or other correspondence that is inconsistent with this section.

History: *2009 c 178 art 1 s 18; 2010 c 384 s 8-10*

60A.40 [Repealed, 1996 c 446 art 1 s 72; 1998 c 339 s 12]

SUBROGATION AGAINST INSURED

60A.41 SUBROGATION AGAINST INSUREDS PROHIBITED.

(a) An insurance company providing insurance coverage or its reinsurer for that underlying insurance coverage may not proceed against its insured in a subrogation action where the loss was caused by the nonintentional acts of the insured.

(b) An insurance company providing insurance coverage or its reinsurer for that underlying insurance coverage may not subrogate itself to the rights of its insured to proceed against another person if that other person is insured for the same loss, by the same company. This provision applies only if the loss was caused by the nonintentional acts of the person against whom subrogation is sought.

(c) This provision does not apply to or affect claims of a surety against its principal.

(d) Nothing in this section prevents an insurer from allocating the loss internally to the at-fault insured for purposes of underwriting, agency, and claims information.

History: *1989 c 201 s 1; 1990 c 399 s 1*

DISABILITY INCOME COVERAGE

60A.42 DISABILITY INCOME COVERAGE; PROHIBITED PROVISION.

No policy, contract, certificate, or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret

the terms of the contract or provide a standard of review that is inconsistent with the laws of this state, or less favorable to the enrollee when a claim is denied than a preponderance of the evidence standard.

History: *2015 c 59 s 1*

60A.43 DISABILITY INCOME COVERAGE; DISCLOSURE.

(a) No contract or policy of long-term disability insurance that limits the duration of coverage for mental health or substance use disorders shall be offered in this state without a disclosure, provided at the time of application, that includes the following:

(1) a notification that the long-term disability coverage selected by the potential policyholder or plan sponsor limits the duration of coverage for mental health or substance use disorders; and

(2) that the potential policyholder or plan sponsor has the right to request more information about the limitation and other coverage options that include an unlimited duration, if available.

(b) Receipt of the disclosure described in paragraph (a) must be acknowledged by the potential policyholder or plan sponsor and evidence of the disclosure and acknowledgment must be retained by the insurance company offering the coverage for a period of no less than two years.

History: *2024 c 114 art 1 s 2*

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS

60A.50 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 60A.50 to 60A.592, the terms in subdivisions 2 to 13 have the meanings given them.

Subd. 2. **Adjusted RBC report.** "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with section 60A.51, subdivision 3.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce or the commissioner of health, whichever commissioner otherwise regulates the health organization.

Subd. 4. **Corrective order.** "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

Subd. 5. **Domestic health organization.** "Domestic health organization" means a health organization domiciled in this state.

Subd. 6. **Foreign health organization.** "Foreign health organization" means a health organization that is licensed to do business in this state but is not domiciled in this state.

Subd. 7. **NAIC.** "NAIC" means the National Association of Insurance Commissioners.

Subd. 8. **Health organization.** "Health organization" means an entity licensed under this chapter or chapter 62C or 62D. This definition does not include an organization that is licensed or regulated as either a life and health insurer or a property and casualty insurer that is otherwise subject to either the life or property and casualty risk-based capital requirements.

Subd. 9. **RBC instructions.** "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

Subd. 10. **RBC level.** "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(1) "company action level RBC" means, with respect to any health organization, the product of 2.0 and its authorized control level RBC;

(2) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(3) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(4) "mandatory control level RBC" means the product of .70 and the authorized control level RBC.

Subd. 11. **RBC plan.** "RBC plan" means a comprehensive financial plan containing the elements specified in section 60A.52, subdivision 2. If the commissioner rejects the RBC plan, and it is revised by the health organization, with or without the commissioner's recommendation, the plan must be called the "revised RBC plan."

Subd. 12. **RBC report.** "RBC report" means the report required in section 60A.51.

Subd. 13. **Total adjusted capital.** "Total adjusted capital" means the sum of:

(1) a health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed; and

(2) such other items, if any, as the RBC instructions may provide.

History: *2004 c 285 art 1 s 1*

60A.51 RBC REPORTS.

Subdivision 1. **Submissions.** A domestic health organization shall, on or before each April 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information required by the RBC instructions. In addition, a domestic health organization shall file its RBC report:

(1) with the NAIC in accordance with the RBC instructions; and

(2) with the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the filing date.

Subd. 2. **Determination.** A health organization's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take the following into account, and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and such other relevant risks as are set forth in the RBC instructions.

Subd. 2a. **Excess of capital.** An excess of capital (net worth) over the amount produced by the risk-based capital requirements contained in sections 60A.50 to 60A.592 and the formulas, schedules, and instructions referenced in sections 60A.50 to 60A.592 is desirable in the business of health insurance.

Subd. 3. **Adjusted report.** If a domestic health organization files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

History: *2004 c 285 art 1 s 2; 2019 c 26 art 3 s 1*

60A.52 COMPANY ACTION LEVEL EVENT.

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

(1) the filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC. If a health organization has total adjusted capital greater than or equal to its company action level RBC but less than the product of its authorized control level RBC multiplied by three, and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(2) notification by the commissioner to the health organization of an adjusted RBC report that indicates an event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56; or

(3) if, pursuant to section 60A.56, a health organization challenges an adjusted RBC report that indicates the event in clause (1), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 2. **RBC plan required.** In the event of a company action level event, the health organization shall prepare and submit to the commissioner an RBC plan that:

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

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

(3) provides projections of the health organization's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

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

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

Subd. 3. **RBC plan submission.** The RBC plan must be submitted:

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

(2) if the health organization challenges an adjusted RBC report pursuant to section 60A.56, within 45 days after notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

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

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

(2) if the health organization challenges the notification from the commissioner under section 60A.56, within 45 days after a notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 5. **Unsatisfactory plan.** In the event of a notification by the commissioner to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, at the commissioner's discretion, subject to the health organization's right to a hearing under section 60A.56, specify in the notification that the notification constitutes a regulatory action level event.

Subd. 6. **Additional filing.** Every domestic health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(1) the state has an RBC provision substantially similar in section 60A.57, subdivision 1; and

(2) the insurance commissioner of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

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

(ii) the date on which the RBC plan or revised RBC plan is filed under subdivisions 3 and 4.

History: *2004 c 285 art 1 s 3; 2019 c 26 art 3 s 2*

60A.53 REGULATORY ACTION LEVEL EVENT.

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

(1) the filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(2) notification by the commissioner to a health organization of an adjusted RBC report that indicates the event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56;

(3) if, pursuant to section 60A.56, the health organization challenges an adjusted RBC report that indicates the event in clause (1), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) the failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(5) the failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in section 60A.52, subdivision 3;

(6) notification by the commissioner to the health organization that:

(i) the RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

(ii) notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under section 60A.56;

(7) if, pursuant to section 60A.56, the health organization challenges a determination by the commissioner under clause (6), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge;

(8) notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under section 60A.50; or

(9) if, pursuant to section 60A.56, the health organization challenges a determination by the commissioner under clause (8), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

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

(1) require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) perform any examination or analysis the commissioner considers necessary of the assets, liabilities, and operations of the health organization, including a review of its RBC plan or revised RBC plan; and

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

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

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

(2) if the health organization challenges an adjusted RBC report pursuant to section 60A.56 and the challenge is not frivolous in the judgment of the commissioner within 45 days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge; or

(3) if the health organization challenges a revised RBC plan pursuant to section 60A.56 and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 4. **Consultants.** The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations, including contractual relationships, of the health organization and formulate the corrective order with respect to the health organization. The fees, costs, and expenses relating to consultants must be borne by the affected health organization or such other party as directed by the commissioner.

History: *2004 c 285 art 1 s 4*

60A.54 AUTHORIZED CONTROL LEVEL EVENT.

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

(1) the filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(2) the notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56;

(3) if, pursuant to section 60A.56, the health organization challenges an adjusted RBC report that indicates the event in clause (1), notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) the failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the health organization has not challenged the corrective order under section 60A.56; or

(5) if the health organization has challenged a corrective order under section 60A.56 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

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

(1) take such actions as are required under section 60A.53 regarding a health organization with respect to which a regulatory action level event has occurred; or

(2) if the commissioner considers it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control under chapter 60B. In the event the commissioner takes such actions, the authorized control level event is considered sufficient grounds for the commissioner to take action under chapter 60B, and the commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in chapter 60B. In the event the commissioner takes actions under this clause pursuant to an adjusted RBC report, the health organization is entitled to the protections afforded health organizations under sections 60B.11 and 60B.13 pertaining to summary proceedings.

History: *2004 c 285 art 1 s 5*

60A.55 MANDATORY CONTROL LEVEL EVENT.

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

(1) the filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

(2) notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56; or

(3) if, pursuant to section 60A.56, the health organization challenges an adjusted RBC report that indicates the event in clause (1), notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 2. **Commissioner's duties.** (a) In the event of a mandatory control level event, the commissioner shall take such actions as are necessary to place the health organization under regulatory control under section 60B.13. In that event, the mandatory control level event is considered sufficient grounds for the commissioner to take action under section 60B.13, and the commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in section 60B.13. If the commissioner takes actions pursuant to an adjusted RBC report, the health organization is entitled to the protections of sections 60B.11 and 60B.13 pertaining to summary proceedings.

(b) Notwithstanding paragraph (a), the commissioner may forgo action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

History: *2004 c 285 art 1 s 6*

60A.56 HEARINGS.

Upon the occurrence of any of the following events, the health organization has the right to a confidential departmental hearing, on a record, at which the health organization may challenge any determination or action by the commissioner. The health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under clause (1), (2), (3), or (4). Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which must be no less than ten nor more than 30 days after the date of the health organization's request. The events include:

(1) notification to a health organization by the commissioner of an adjusted RBC report;

(2) notification to a health organization by the commissioner that:

(i) the health organization's RBC plan or revised RBC plan is unsatisfactory; and

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

(3) notification to a health organization by the commissioner that the health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

(4) notification to a health organization by the commissioner of a corrective order with respect to the health organization.

History: *2004 c 285 art 1 s 7*

60A.57 ACCESS TO AND USE OF RBC INFORMATION.

Subdivision 1. **Confidentiality; prohibition on announcements.** Section 60A.67, subdivisions 1 and 2, apply to sections 60A.50 to 60A.592.

Subd. 2. **Prohibition for rate making or premium setting.** The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the commissioner for rate making nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

History: *2004 c 285 art 1 s 8*

60A.58 SUPPLEMENTAL PROVISIONS.

Subdivision 1. **Effect.** Sections 60A.50 to 60A.592 are supplemental to any other provisions of the laws of this state, and must not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, chapter 60B and sections 62D.041, 62D.042, 62D.18, and 62D.181.

Subd. 2. **Exemption.** The commissioner may exempt from the application of sections 60A.50 to 60A.592 a domestic health organization that:

(1) writes direct business only in this state;

(2) assumes no reinsurance in excess of five percent of direct premium written; and

(3) writes direct annual premiums for comprehensive medical business of $2,000,000 or less.

History: *2004 c 285 art 1 s 9*

60A.59 FOREIGN HEALTH ORGANIZATIONS.

Subdivision 1. **RBC report.** (a) A foreign health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended the later of:

(1) the date an RBC report would be required to be filed by a domestic health organization under sections 60A.50 to 60A.592; or

(2) 15 days after the request is received by the foreign health organization.

(b) A foreign health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

Subd. 2. **RBC plan.** In the event of a company action level event, regulatory action level event, or authorized control level event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization or, if no RBC statute is in force in that state, under sections 60A.50 to 60A.592, if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, under section 60A.52, the commissioner may require the foreign health organization to file an RBC plan with the commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the commissioner shall be grounds to order the health organization to cease and desist from writing new insurance business in this state. This section does not limit the commissioner's authority to require a foreign insurer to file a copy of the risk-based capital plan submitted to the commissioner in the state of domicile.

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

History: *2004 c 285 art 1 s 10*

60A.591 IMMUNITY.

There is no liability on the part of, and no cause of action arises against, the commissioner or the department or its employees or agents for any action taken by them in the performance of their powers and duties under sections 60A.50 to 60A.592.

History: *2004 c 285 art 1 s 11*

60A.592 NOTICES.

All notices by the commissioner to a health organization that may result in regulatory action under sections 60A.50 to 60A.592 are effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission are effective upon the health organization's receipt of notice.

History: *2004 c 285 art 1 s 12*

REGULATION OF RISK-BASED CAPITAL

60A.60 DEFINITIONS.

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

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

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

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

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

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

Subd. 7. **Life and/or health insurer.** "Life and/or health insurer" means an insurance company authorized to transact business under section 60A.06, subdivision 1, clause (4), or a property and casualty insurer transacting business only under section 60A.06, subdivision 1, clause (5)(a).

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

Subd. 9. **Negative trend.** "Negative trend" means negative trend over a period of time, as determined according to the "trend test calculation" included in the risk-based capital instructions.

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

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

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

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

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

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

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

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

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

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

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

History: *1995 c 253 s 2; 2011 c 61 s 2*

60A.61 RISK-BASED CAPITAL REPORTS.

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

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

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

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

(ii) March 1.

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

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

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

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

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

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

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

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

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

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

Subd. 4. **Maintaining additional capital.** An excess of capital over the amount produced by the risk-based capital requirements contained in sections 60A.60 to 60A.696 and the formulas, schedules, and instructions

referenced in sections 60A.60 to 60A.696 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the risk-based capital levels required by sections 60A.60 to 60A.696. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in sections 60A.60 to 60A.696.

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

History: *1995 c 253 s 3*

60A.62 COMPANY ACTION LEVEL EVENT.

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

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

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

(ii) if a life and/or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and has a negative trend; or

(iii) if a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions;

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

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

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

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

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

(3) provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projected statutory balance sheets, income statements, and cash flow statements. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1995 c 253 s 4; 2013 c 135 art 3 s 8*

60A.63 REGULATORY ACTION LEVEL EVENT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Examination and review.** The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the insurer's risk-based capital plan or revised risk-based capital plan, examine or analyze the assets, liabilities, and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or other party as directed by the commissioner.

History: *1995 c 253 s 5*

60A.64 AUTHORIZED CONTROL LEVEL EVENT.

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

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

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

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

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

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

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

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

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

History: *1995 c 253 s 6*

60A.65 MANDATORY CONTROL LEVEL EVENT.

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

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

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

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

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

(1) with respect to a life and/or health insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under chapter 60B. In that event, the mandatory control level event is considered sufficient grounds for the commissioner to take action under chapter 60B, and the commissioner has the rights, powers, and duties with respect to the insurer set forth in chapter 60B. If the commissioner takes actions pursuant to an adjusted risk-based capital report, the insurer is entitled to the protections of section 60B.11 pertaining to summary proceedings. However, the commissioner may forgo action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period; and

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

History: *1995 c 253 s 7*

60A.66 HEARINGS.

Upon:

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

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

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

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

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

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

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

History: *1995 c 253 s 8*

60A.67 CONFIDENTIALITY.

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

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

risk-based capital levels is published in a written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement. This subdivision does not prohibit an insurance company or its holding company from disclosing information about its risk-based capital levels in the notes to its financial statements if required by pronouncements of the American Institute of Certified Public Accountants or the Financial Accounting Standards Board, or making this disclosure as required by other governmental regulatory agencies.

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

History: *1995 c 253 s 9; 1996 c 446 art 2 s 6*

60A.68 SUPPLEMENTAL PROVISIONS; RULES; EXEMPTION.

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

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

(1) writes direct business only in this state;

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

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

History: *1995 c 253 s 10*

60A.69 FOREIGN INSURERS.

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

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

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

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

Subd. 2. **A risk-based capital plan requirement.** In the event of a company action level event, regulatory action level event, or authorized control level event with respect to a foreign insurer as determined under

the risk-based capital statute applicable in the state of domicile of the insurer, or, if no risk-based capital statute is in force in that state, under sections 60A.60 to 60A.696, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under that state's risk-based capital statute, or, if no risk-based capital statute is in force in that state, under section 60A.62, the commissioner may require the foreign insurer to file a risk-based capital plan with the commissioner. In this event, the failure of the foreign insurer to file a risk-based capital plan with the commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state. This section does not limit the commissioner's authority to require a foreign insurer to file a copy of the risk-based capital plan submitted to the commissioner in the state of domicile.

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

History: *1995 c 253 s 11*

60A.695 IMMUNITY.

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

History: *1995 c 253 s 12*

60A.696 NOTICES.

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

History: *1995 c 253 s 13*

REINSURANCE INTERMEDIARY ACT

60A.70 TITLE.

Sections 60A.70 to 60A.756 may be cited as the "Reinsurance Intermediary Act."

History: *1991 c 325 art 11 s 1*

60A.705 DEFINITIONS.

Subdivision 1. **Terms.** For purposes of sections 60A.70 to 60A.756, the terms defined in this section have the meanings given them.

Subd. 2. **Actuary.** "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

Subd. 3. **Controlling person.** "Controlling person" means a person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of the reinsurance intermediary.

Subd. 4. **Insurer.** "Insurer" means any person, firm, association, or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer.

Subd. 5. **Licensed producer.** "Licensed producer" means an agent, broker, or reinsurance intermediary licensed pursuant to the applicable provision of the insurance law.

Subd. 6. **Reinsurance intermediary.** "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

Subd. 7. **Reinsurance intermediary-broker; RB.** "Reinsurance intermediary-broker" or "RB" means any person, other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of this insurer.

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

(1) an employee of the reinsurer;

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

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

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

Subd. 9. **Reinsurer.** "Reinsurer" means a person, firm, association, or corporation licensed in this state as an insurer with the authority to assume reinsurance.

Subd. 10. **To be in violation.** "To be in violation" means that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of sections 60A.70 to 60A.756.

Subd. 11. **Qualified United States financial institution.** "Qualified United States financial institution" means an institution that:

(1) is organized, or in the case of a United States office of a foreign banking organization, is licensed, under the laws of the United States or any state;

(2) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) has been determined by either the commissioner, or the securities valuation office of the National Association of Insurance Commissioners, to meet the standards of financial condition and standing considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

History: *1991 c 325 art 11 s 2; 1995 c 214 s 10*

60A.71 LICENSURE.

Subdivision 1. **Reinsurance intermediary-broker requirements.** No person, firm, association, or corporation shall act as an RB in this state if the RB maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation:

(1) in this state, unless the RB is a licensed producer in this state; or

(2) in another state, unless the RB is a licensed producer in this state or another state having a law substantially similar to this law or the RB is licensed in this state as a nonresident reinsurance intermediary.

Subd. 2. **Reinsurance intermediary-manager requirements.** No person, firm, association, or corporation shall act as an RM:

(1) for a reinsurer domiciled in this state, unless the RM is a licensed producer in this state;

(2) in this state, if the RM maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation in this state, unless the RM is a licensed producer in this state; or

(3) in another state for a nondomestic insurer, unless the RM is a licensed producer in this state or another state having a law substantially similar to this law or the person is licensed in this state as a nonresident reinsurance intermediary.

Subd. 3. **Bond and insurance requirements for reinsurance intermediary-manager.** The commissioner may require an RM subject to subdivision 2 to:

(1) file a bond in an amount from an insurer acceptable to the commissioner for the protection of the reinsurer; and

(2) maintain an errors and omissions policy in an amount acceptable to the commissioner.

Subd. 4. **Terms.** (a) The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation who has complied with the requirements of sections 60A.70 to 60A.756. The license issued to a firm or association will authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and these persons shall be named in the application and any supplements to it. The license issued to a corporation shall authorize all of the officers, and any designated employees and directors of the corporation to act as reinsurance intermediaries on behalf of the corporation, and all these persons shall be named in the application and any supplements to it.

(b) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by sections 60A.70 to 60A.756 for designation of service of process upon unauthorized insurers. The applicant shall also furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process

affecting the nonresident reinsurance intermediary may be served. The licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and the change shall not become effective until acknowledged by the commissioner.

Subd. 5. **Refusal to issue.** The commissioner may refuse to issue a reinsurance intermediary license if, in the commissioner's judgment, the applicant, anyone named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy, or that any controlling person of the applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of the license, or has failed to comply with any prerequisite for the issuance of the license. Upon written request, the commissioner will furnish a summary of the basis for refusal to issue a license. This document is privileged and not subject to chapter 13.

Subd. 6. **Attorneys exemption.** Licensed attorneys at law of this state when acting in their professional capacity as such are exempt from this section.

Subd. 7. **Duration; fees.** (a) Each applicant for a reinsurance intermediary license shall pay to the commissioner a fee of $200 for an initial two-year license and a fee of $150 for each renewal. Applications shall be submitted on forms prescribed by the commissioner.

(b) Initial licenses issued under this chapter are valid for a period not to exceed 24 months and expire on October 31 of the renewal year assigned by the commissioner. Each renewal reinsurance intermediary license is valid for a period of 24 months.

(c) All fees are nonreturnable, except that an overpayment of any fee may be refunded upon proper application.

History: *1991 c 325 art 11 s 3; 1997 c 200 art 1 s 42; 1999 c 223 art 2 s 6; 2008 c 344 s 6; 1Sp2021 c 4 art 3 s 4*

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

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

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

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

(3) all funds collected for the ceding insurer's or the assuming reinsurer's account will be held by the RB in a fiduciary capacity:

(i) in a bank that is a qualified United States financial institution; or

(ii) in direct obligations of, or obligations guaranteed or insured by, the United States, its agencies, or its instrumentalities, excluding mortgage-backed securities, or in obligations described in section 60A.11, subdivision 17, paragraphs (a) and (b).

Investments made under item (ii) must be traded on a national securities exchange, and shall be restricted to the following: direct obligations of the United States government or an agency of the United States government, municipal bonds or corporate bonds or notes with credit ratings of at least AA by Standard &

Poors or equivalent ratings from a comparable rating service, or commercial paper with a short-term rating of at least A-1 by Standard & Poors or an equivalent rating from a comparable rating service, but in no event shall the obligations be rated other than in the highest category established by the Securities Valuation Office of the National Association of Insurance Commissioners. The RB shall invest fiduciary funds under item (ii) only if authorized in writing by the ceding insurer or assuming reinsurer in whose account the funds are held, shall secure the investments with security acceptable to the ceding insurer or assuming reinsurer on whose account the funds are held, and shall be responsible for any losses on investments made pursuant to item (ii).

At least 50 percent of the funds invested under clause (3), based on the prior 30 days' average balance, must be invested in instruments that mature in no more than 120 days. In no case shall an investment mature in greater than three years from the date of purchase. Investments made pursuant to clause (3) should emphasize safety, liquidity, and diversification. The RB is required to structure those investments so that funds are available to remit on a timely basis to the ceding insurer or the assuming reinsurer in accordance with clause (2);

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

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

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

History: *1991 c 325 art 11 s 4; 1995 c 163 s 1; 1998 c 323 s 1*

60A.72 BOOKS AND RECORDS; REINSURANCE INTERMEDIARY-BROKERS.

Subdivision 1. **Records of transactions.** For at least ten years after expiration of each contract of reinsurance transacted by the RB, the RB will keep a complete record for each transaction showing:

(1) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation;

(3) reporting and settlement requirements of balances;

(4) rate used to compute the reinsurance premium;

(5) names and addresses of assuming reinsurers;

(6) rates of all reinsurance commissioners, including the commissions on any retrocessions handled by the RB;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the RB including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) financial records, including, but not limited to, premium and loss accounts; and

(11) when the RB procures a reinsurance contract on behalf of a licensed ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

Subd. 2. **Access by insurer.** The insurer will have access and the right to copy and audit all accounts and records maintained by the RB related to its business in a form usable by the insurer.

History: *1991 c 325 art 11 s 5*

60A.725 DUTIES OF INSURERS UTILIZING THE SERVICES OF A REINSURANCE INTERMEDIARY-BROKER.

(a) An insurer shall not engage the services of a person, firm, association, or corporation to act as an RB on its behalf unless the person is licensed as required by section 60A.71, subdivision 1.

(b) An insurer may not employ an individual who is employed by an RB with which it transacts business, unless the RB is under common control with the insurer and subject to chapter 60D.

(c) The insurer shall annually obtain a copy of statements of the financial condition of each RB with which it transacts business.

History: *1991 c 325 art 11 s 6*

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

Subdivision 1. **Approval by commissioner.** Transactions between an RM and the reinsurer it represents in this capacity must only be entered into pursuant to a written contract, specifying the responsibilities of each party. The contract shall be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through this producer, a true copy of the approved contract must be filed with the commissioner for approval. The contract must, at a minimum, contain the provisions in subdivisions 2 to 14.

Subd. 2. **Terminations.** The reinsurer may terminate the contract for cause upon written notice to the RM. The reinsurer may immediately suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination.

Subd. 3. **Periodic accounting.** The RM will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to the RM, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

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

Subd. 5. **Business records.** For at least ten years after expiration of each contract of reinsurance transacted by the RM, the RM will keep a complete record for each transaction showing:

(1) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(3) reporting and settlement requirements of balances;

(4) rate used to compute the reinsurance premium;

(5) names and addresses of reinsurers;

(6) rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the RM, as permitted by section 60A.74, subdivision 4, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) financial records, including, but not limited to, premium and loss accounts; and

(11) when the RM places a reinsurance contract on behalf of a ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

Subd. 6. **Reinsurer access to records.** The reinsurer will have access and the right to copy all accounts and records maintained by the RM related to its business in a form usable by the reinsurer.

Subd. 7. **Nonassignment of contract.** The contract cannot be assigned in whole or in part by the RM.

Subd. 8. **Underwriting and rating standards.** The RM will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

Subd. 9. **Charges and commissions.** The rates, terms and purposes of commission, charges, and other fees which the RM may levy against the reinsurer will be specified in the contract.

Subd. 10. **Claims settlement.** If the contract permits the RM to settle claims on behalf of the reinsurer, the contract will specify that:

(1) all claims will be reported to the reinsurer in a timely manner;

(2) a copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(ii) involves a coverage dispute;

(iii) may exceed the RM's claims settlement authority;

(iv) is open for more than six months; or

(v) is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer;

(3) all claim files will be the joint property of the reinsurer and RM. However, upon an order of liquidation of the reinsurer the files become the sole property of the reinsurer or its estate. The RM shall have reasonable access to and the right to copy the files on a timely basis; and

(4) settlement authority granted to the RM may be terminated for cause upon the reinsurer's written notice to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

Subd. 11. **Interim profits.** If the contract provides for a sharing of interim profits by the RM, interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later period set by the commissioner for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to section 60A.74, subdivision 3.

Subd. 12. **Certified financial statement.** The RM will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

Subd. 13. **On-site review by reinsurer.** The reinsurer shall periodically, at least semiannually, conduct an on-site review of the underwriting and claims processing operations of the RM.

Subd. 14. **Disclosure of insurer relationship.** The RM will disclose to the reinsurer any relationship it has with any insurer before ceding or assuming any business with the insurer pursuant to this contract.

Subd. 15. **Responsibility of reinsurer.** Within the scope of its actual or apparent authority, the acts of the RM are considered to be the acts of the reinsurer on whose behalf it is acting.

History: *1991 c 325 art 11 s 7; 1995 c 163 s 2*

60A.735 PROHIBITED ACTS.

The RM shall not:

(1) cede retrocessions on behalf of the reinsurer, except that the RM may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for these retrocessions. These guidelines must include a list of reinsurers with which these automatic agreements are in effect, and for each reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(2) commit the reinsurer to participate in reinsurance syndicates;

(3) appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which the producer is appointed;

(4) without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

(5) collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer;

(6) jointly employ an individual who is employed by the reinsurer unless such RM is under common control with the reinsurer subject to chapter 60D;

(7) appoint a sub-RM.

History: *1991 c 325 art 11 s 8*

60A.74 DUTIES OF REINSURER UTILIZING THE SERVICES OF A REINSURANCE INTERMEDIARY-MANAGER.

Subdivision 1. **Licensed persons to be used.** A reinsurer shall not engage the services of any person, firm, association, or corporation to act as an RM on its behalf unless the person is licensed as required by section 60A.71, subdivision 2.

Subd. 2. **Annual financial statements to be obtained.** The reinsurer shall annually obtain a copy of statements of the financial condition of each RM which the reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the commissioner.

Subd. 3. **Loss reserve opinions.** If an RM establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion must be in addition to any other required loss reserve certification.

Subd. 4. **Binding authority.** Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the RM.

Subd. 5. **Notification of termination.** Within 30 days of termination of a contract with an RM, the reinsurer shall provide written notification of the termination to the commissioner.

Subd. 6. **Restriction on board appointments.** A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder, or subproducer of its RM. This subdivision does not apply to relationships governed by chapter 60D or, if applicable, the Business Transacted With Producer Controlled Insurer Act, sections 60J.06 to 60J.11.

History: *1991 c 325 art 11 s 9; 1993 c 13 art 1 s 16; 2000 c 260 s 12*

60A.745 EXAMINATION AUTHORITY; REINSURANCE INTERMEDIARY - BROKER.

(a) A reinsurance intermediary is subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

(b) An RM may be examined as if it were the reinsurer.

History: *1991 c 325 art 11 s 10*

60A.75 VIOLATIONS.

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

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

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

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

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

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

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

History: *1991 c 325 art 11 s 11; 1995 c 214 s 11*

60A.755 SCOPE.

Nothing contained in sections 60A.70 to 60A.756 is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights to these persons.

History: *1991 c 325 art 11 s 12*

60A.756 RULES.

The commissioner may adopt rules for the implementation and administration of sections 60A.70 to 60A.756.

History: *1991 c 325 art 11 s 13*

MINIMUM STANDARD OF VALUATION FOR HEALTH INSURANCE

60A.76 PURPOSE AND SCOPE.

Sections 60A.76 to 60A.768 apply to all individual and group accident and health insurance coverages as defined in section 60A.06, subdivision 1, paragraph (5)(a), including single premium credit disability insurance. Other credit insurance is not subject to sections 60A.76 to 60A.768.

When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified in sections 60A.76 to 60A.768, the increased reserves must be held and must be considered the minimum reserves for that insurer.

With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. The prospective gross premium valuation must take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

The prospective gross premium valuation must be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition must be made and the reserves restored to adequacy. Adequate reserves, inclusive of claim, premium, and contract reserves, if any, must be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under sections 60A.76 to 60A.768.

Whenever minimum reserves, as defined in sections 60A.76 to 60A.768, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under sections 60A.76 to 60A.768.

History: *2004 c 285 art 2 s 1*

60A.761 GLOSSARY OF TECHNICAL TERMS USED.

Subdivision 1. **Scope.** As used in sections 60A.76 to 60A.768, the terms in subdivisions 2 to 21 have the meanings given them.

Subd. 2. **Annual claim cost.** "Annual claim cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a $100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12, while the gross premium for this benefit might be $18. The additional $6 would cover expenses and profit or contingencies.

Subd. 3. **Claims accrued.** "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or before the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

Subd. 4. **Claims reported.** "Claims reported" means when an insurer has been informed that a claim has been incurred, if the date reported is on or before the valuation date, the claim is considered as a reported claim for annual statement purposes.

Subd. 5. **Claims unaccrued.** "Claims unaccrued" means that portion of claims incurred on or before the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for "unaccrued" benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest) must be established.

Subd. 6. **Claims unreported.** "Claims unreported" means when an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

Subd. 7. **Date of disablement.** "Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

Subd. 8. **Elimination period.** "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

Subd. 9. **Gross premium.** "Gross premium" means the amount of premium charged by the insurer. It includes the net premium (based on claim cost) for the risk, together with any loading for expenses, profit, or contingencies.

Subd. 10. **Group insurance.** "Group insurance" includes blanket insurance and franchise insurance and any other forms of group insurance.

Subd. 11. **Level premium.** "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time.

Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case, the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

Subd. 12. **Long-term care insurance.** "Long-term care insurance" means a qualified long-term care insurance policy or rider as defined in section 62S.01, subdivision 18, and a nonqualified long-term insurance policy or rider as defined in section 62A.46, subdivision 2.

Subd. 13. **Modal premium.** "Modal premium" refers to the premium paid on a contract based on a premium term which could be annual, semiannual, quarterly, monthly, or weekly. Thus if the annual premium is $100 and if, instead, monthly premiums of $9 are paid then the modal premium is $9.

Subd. 14. **Negative reserve.** "Negative reserve" means normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

Subd. 15. **Preliminary term reserve method.** "Preliminary term reserve method" means that under this method of valuation the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

Subd. 16. **Present value of amounts not yet due on claims.** "Present value of amounts not yet due on claims" means the reserve for "claims unaccrued" which may be discounted at interest.

Subd. 17. **Rating block.** "Rating block" means a grouping of contracts determined by the valuation actuary based on common characteristics, such as a policy form or forms having similar benefit designs.

Subd. 18. **Reserve.** "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

An insurer under its contracts promises benefits, which result in:

(a) claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(b) claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

Subd. 19. **Terminal reserve.** "Terminal reserve" means the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

Subd. 20. **Unearned premium reserve.** "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of $120 was paid on November 1, $20 would be earned as of December 31 and the remaining $100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

Subd. 21. **Valuation net modal premium.** "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

History: *2004 c 285 art 2 s 2*

60A.762 CATEGORIES OF RESERVES.

The following sections set forth minimum standards for three categories of health insurance reserves:

(1) section 60A.763, claim reserves;

(2) section 60A.764, premium reserves; and

(3) section 60A.765, contract reserves.

Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, sections 60A.76 to 60A.768 emphasize the importance of determining appropriate reserves for each of the three categories separately.

History: *2004 c 285 art 2 s 3*

60A.763 CLAIM RESERVES.

Subdivision 1. **Generally.** (a) Claim reserves are required for all incurred but unpaid claims on all health insurance policies.

(b) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

(c) Claim reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

Subd. 2. **Minimum standards for claim reserves for disability income.** (a) The maximum interest rate for claim reserves is specified in section 60A.768.

(b) Minimum standards with respect to morbidity are those specified in section 60A.768, except that, at the option of the insurer:

(1) for claims with a duration from date of disablement of less than two years, reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities; and

(2) for group disability income claims with a duration from date of disablement of more than two years but less than five years, reserves may, with the approval of the commissioner, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for approval of a plan of modification to the reserve basis must include:

(i) an analysis of the credibility of the experience;

(ii) a description of how all of the insurer's experience is proposed to be used in setting reserves;

(iii) a description and quantification of the margins to be included;

(iv) a summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(v) a copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and

(vi) any other information deemed necessary by the commissioner.

(c) For contracts with an elimination period, the duration of disablement must be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

Subd. 3. **Minimum standards for claim reserves for all other benefits.** (a) The maximum interest rate for claim reserves is specified in section 60A.768.

(b) The reserve must be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

Subd. 4. **Claim reserve methods generally.** A generally accepted actuarial reserving method or other reasonable method if the method is approved by the commissioner before the statement date, or a combination of methods as described in this section, may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued.

Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, must be determined in the aggregate.

History: *2004 c 285 art 2 s 4*

60A.764 PREMIUM RESERVES.

Subdivision 1. **Generally.** (a) Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) If premiums due and unpaid are carried as an asset, the premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums must be carried as an offsetting liability.

(c) The gross premiums paid in advance for a period of coverage beginning after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and must be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

Subd. 2. **Minimum standards for unearned premium reserves.** (a) The minimum unearned premium reserve with respect to a contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with the premium determined on the basis of:

(1) the valuation net modal premium on the contract reserve basis applying to the contract; or

(2) the gross modal premium for the contract if no contract reserve applies.

(b) However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. The reserve must never be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for elsewhere.

Subd. 3. **Premium reserve methods generally.** The insurer may employ suitable approximations and estimates, including, but not limited to, groupings, averages, and aggregate estimation, in computing premium reserves. Approximations or estimates should be tested periodically to determine the continuing adequacy and reliability.

History: *2004 c 285 art 2 s 5*

60A.765 CONTRACT RESERVES REQUIRED.

(a) Contract reserves are required, unless otherwise specified in paragraph (b) for:

(1) all individual and group contracts with which level premiums are used; or

(2) all individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary must state in the certification that

premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary must also disclose the reasons for and magnitude of the recovery. The values specified in this clause must be determined on the basis specified in section 60A.766, subdivisions 1 to 4.

(b) Contracts not requiring a contract reserve are:

(1) contracts that cannot be continued after one year from issue; or

(2) contracts already in force on August 1, 2004, for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves.

(d) The methods and procedures for contract reserves must be consistent with those for claim reserves for a contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

History: *2004 c 285 art 2 s 6*

60A.766 MINIMUM STANDARDS FOR CONTRACT RESERVES.

Subdivision 1. **Basis.** (a) Minimum standards with respect to morbidity are those set forth in section 60A.768. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration, and period for which gross premiums have been calculated.

Contracts for which tabular morbidity standards are not specified in section 60A.768 must be valued using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner. The morbidity tables must contain a pattern of incurred claims cost that reflects the underlying morbidity and must not be constructed for the primary purpose of minimizing reserves.

(b) The maximum interest rate is specified in section 60A.768.

(c) Termination rates used in the computation of reserves must be on the basis of a mortality table as specified in section 60A.768 except as noted in clauses (1) to (3):

(1) under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) 80 percent of the total termination rate used in the calculation of the gross premiums; or

(ii) eight percent;

(2) for long-term care individual policies or group certificates issued after January 1, 1997, the contract reserve may be established on a basis of separate:

(i) mortality as specified in section 60A.768; and

(ii) terminations other than mortality, where the terminations are not to exceed:

A. for policy years one through four, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums and eight percent;

B. for policy years five and later, the lesser of 100 percent of the voluntary lapse rate used in the calculation of gross premiums and four percent;

(3) where a morbidity standard specified in section 60A.768 is on an aggregate basis, the morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the commissioner.

Subd. 2. **Reserve method.** (a) For insurance, except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(b) For long-term care insurance, the minimum reserve is the reserve calculated as follows:

(1) for individual policies and group certificates issued on or before December 31, 1991, reserves calculated on the two-year full preliminary term methods;

(2) for individual policies and group certificates issued on or after January 1, 1992, reserves calculated on the one-year full preliminary term method.

(c) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(1) on the one-year preliminary term method if the benefits are provided at any time before the 20th anniversary;

(2) on the two-year preliminary term method if the benefits are only provided on or after the 20th anniversary.

The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions, for example projected inflation rates, or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

Subd. 3. **Negative reserves.** Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

Subd. 4. **Nonforfeiture benefits for long-term care insurance.** The contract reserve on a policy basis must not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the specifications in this section. While the consideration for nonforfeiture benefits in this section is specific to long-term care insurance, similar consideration may be applicable for other lines of business.

Subd. 5. **Alternative valuation methods and assumptions generally.** Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified in this section, an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated in this section in determining a sound value of its liabilities under such contracts, including, but not limited to, the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts

of indemnity, and grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

Subd. 6. **Test for adequacy and reasonableness of contract reserves.** Annually, an appropriate review must be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of subdivisions 1 to 4.

In the event a company has a contract or a group of related similar contracts for which future gross premiums will be restricted by contract, department rule, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

History: *2004 c 285 art 2 s 7*

60A.767 REINSURANCE.

Increases to or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with sections 60A.76 to 60A.768 and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

History: *2004 c 285 art 2 s 8*

60A.768 SPECIFIC STANDARDS FOR MORBIDITY, INTEREST, AND MORTALITY.

Subdivision 1. **Morbidity.** A. Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness.

(a) Contract Reserves:

Contracts issued on or after January 1, 2004:

The 1985 Commissioners Individual Disability Tables A (85CIDA); or

The 1985 Commissioners Individual Disability Tables B (85CIDB).

Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(b) Claim Reserves:

For claims incurred on or after January 1, 2004:

The 1985 Commissioners Individual Disability Table A (85CIDA) with claim termination rates multiplied by the following adjustment factors:

	Duration	Adjustment Factor	Adjusted Termination Rates*
Week	1	0.366	0.04831
	2	0.366	0.04172
	3	0.366	0.04063
	4	0.366	0.04355
	5	0.365	0.04088
	6	0.365	0.04271
	7	0.365	0.04380
	8	0.365	0.04344
	9	0.370	0.04292
	10	0.370	0.04107
	11	0.370	0.03848
	12	0.370	0.03478
	13	0.370	0.03034
Month	4	0.391	0.08758
	5	0.371	0.07346
	6	0.435	0.07531
	7	0.500	0.07245
	8	0.564	0.06655
	9	0.613	0.05520
	10	0.663	0.04705
	11	0.712	0.04486
	12	0.756	0.04309
	13	0.800	0.04080
	14	0.844	0.03882
	15	0.888	0.03730
	16	0.932	0.03448
	17	0.976	0.03026
	18	1.020	0.02856

	19	1.049	0.02518
	20	1.078	0.02264
	21	1.107	0.02104
	22	1.136	0.01932
	23	1.165	0.01865
	24	1.195	0.01792
Year	3	1.369	0.16839
	4	1.204	0.10114
	5	1.199	0.07434
	6 and later	1.000	**

*The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (Transactions of the Society of Actuaries (TSA) XXXVII, pages 457-463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

**Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (TSA XXXVII, pages 462-463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85CIDC (The 1985 Commissioners Individual Disability Table C).

(2) Hospital Benefits, Surgical Benefits, and Maternity Benefits (Scheduled benefits or fixed time period benefits only).

(a) Contract Reserves.

Contracts issued on or after January 1, 1982:

The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, page 63. Refer to the paper (in the same volume, page 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(b) Claim Reserves:

No specific standard. See (6).

(3) Cancer Expense Benefits (Scheduled benefits or fixed time period benefits only).

(a) Contract Reserves:

Contracts issued on or after January 1, 2004:

The 1985 NAIC Cancer Claim Cost Tables.

(b) Claim Reserves:

No specific standard. See (6).

(4) Accidental Death Benefits.

(a) Contract Reserves:

Contracts issued on or after January 1, 2004:

The 1959 Accidental Death Benefits Table.

(b) Claim Reserves:

Actual amount incurred.

(5) Single Premium Credit Disability.

(a) Contract Reserves:

(i) For contracts issued on or after January 1, 2004:

(I) For plans having less than a 30-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by 12 percent.

(ii)(II) For plans having a 30-day and greater elimination period, the 85CIDA for a 14-day elimination period with the adjustment in item (I).

(b) Claim Reserves:

Claim reserves are to be determined as provided in section 60A.763.

(6) Other Individual Contract Benefits.

(a) Contract Reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in section 60A.765.

(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in section 60A.763.

B. Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness.

(a) Contract Reserves:

Contracts issued on or after January 1, 2004:

The 1987 Commissioners Group Disability Income Table (87CGDT).

(b) Claim Reserves:

For claims incurred on or after January 1, 2004:

The 1987 Commissioners Group Disability Income Table (87CGDT);

(2) Single Premium Credit Disability.

(a) Contract Reserves:

(i) For contracts issued on or after January 1, 2004:

(I) For plans having less than a 30-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by 12 percent.

(ii)(II) For plans having a 30-day and greater elimination period, the 85CIDA for a 14-day elimination period with the adjustment in item (I).

(b) Claim Reserves:

Claim reserves are to be determined as provided in section 60A.763.

(3) Other Group Contract Benefits.

(a) Contract Reserves:

For all other group contract benefits, morbidity assumptions are to be determined as provided in section 60A.765.

(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in section 60A.763.

Subd. 2. **Interest.** A. For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

B. For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurred date.

C. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurred date, reduced by 100 basis points.

Subd. 3. **Mortality.** A. For individual long-term care insurance policies or group long-term care insurance certificates issued on or after January 1, 2004, the mortality basis used must be the 1983 Group Annuity Mortality Table without projection.

B. Other mortality tables adopted by the NAIC and adopted by the commissioner may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the commissioner. The request for approval must include the proposed mortality table and the reason that the standard specified in subsection A is inappropriate.

C. For single premium credit insurance using the 85CIDA table, no separate mortality must be assumed.

History: *2004 c 285 art 2 s 9*

REINSURANCE AGREEMENTS

60A.80 [Repealed, 1994 c 426 s 14]

60A.801 [Repealed, 1994 c 426 s 14]

60A.802 [Repealed, 1994 c 426 s 14]

60A.803 LIFE AND HEALTH REINSURANCE AGREEMENTS.

Subdivision 1. **Scope.** This section applies to:

(1) all domestic life and accident and sickness insurers;

(2) all other licensed life and accident and sickness insurers which are not subject to a substantially similar regulation in their domiciliary state; and

(3) licensed insurers with respect to their accident and sickness business.

This section does not apply to assumption reinsurance, yearly renewable term reinsurance, or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

Subd. 2. **Accounting requirements.** No insurer subject to this section shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the commissioner if, by the terms of the reinsurance agreement, in substance or effect, any of the conditions in paragraphs (a) to (k) exist:

(a) The renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall, using assumptions equal to the applicable statutory reserve basis on the business reinsured. Those expenses include commissions, premium taxes, and direct expenses including, but not limited to, billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured.

(b) The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be a deprivation of surplus or assets.

(c) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer is considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty.

(d) The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded.

(e) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. It is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer, which are greater than the direct premiums collected by the ceding company.

(f) The reinsurance agreement does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies, for a representative sampling of products or type of business, the risks that are considered to be significant. For products not specifically included, the risks determined to be significant must be consistent with this table.

Risk categories:

(1) morbidity;

(2) mortality;

(3) lapse, which is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy;

(4) credit quality (C1), which is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate;

(5) reinvestment (C3), which is the risk that interest rates will fall and funds reinvested (coupon payments or money received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase; and

(6) disintermediation (C3), which is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

RISK CATEGORY

+ = Significant

0 = Insignificant

	1	2	3	4	5	6
Health Insurance - other than LTC/LTD*	+	0	+	0	0	0
Health Insurance - LTC/LTD*	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Nonpar Permanent	0	+	+	+	+	+
Traditional Nonpar Term	0	+	+	0	0	0

Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium (dump-in premiums allowed)	0	+	+	+	+	+

*LTC = Long-Term Care Insurance

LTD = Long-Term Disability Insurance

(g)(1) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not, other than for the classes of business excepted in clause (2), either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner that legally segregates, by contract or contract provision, the underlying assets.

(2) Notwithstanding the requirements of clause (1), the assets supporting the reserves for the following classes of business and any classes of business that do not have a significant credit quality, reinvestment or disintermediation risk, may be held by the ceding company without segregation of the assets:

(i) Health Insurance - LTC/LTD;

(ii) Traditional Nonpar Permanent;

(iii) Traditional Par Permanent;

(iv) Adjustable Premium Permanent;

(v) Indeterminate Premium Permanent; and/or

(vi) Universal Life Fixed Premium (no dump-in premiums allowed).

The associated formula for determining the reserve interest rate adjustment must reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

Rate = 2(I+CG) / (X + Y - I - CG)

Where: I is the net investment income

CG is capital gains less capital losses

X is the current year cash and invested assets plus investment income due and accrued less borrowed money

Y is the same as X but for the prior year

(h) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.

(i) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

(j) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

(k) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

Subd. 3. **Commissioner approval.** Notwithstanding subdivision 2, an insurer subject to this section may, with the prior approval of the commissioner, take such reserve credit or establish such asset as the commissioner deems consistent with state insurance law or rules.

Subd. 4. **Filing.** (a) Agreements entered into after August 1, 1994, that involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within 30 days from their date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this section and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the commissioner. The actuary shall maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that the work conforms to this section.

(b) Any increase in surplus net of federal income tax resulting from arrangements described in paragraph (a) must be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the capital and surplus account of the annual statement) and recognition of the surplus increase as income must be reflected on a net of tax basis in the "Reinsurance ceded" line of the annual statement as earnings emerge from the business reinsured.

Subd. 5. **Written agreements.** No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the commissioner, unless the agreement, amendment, or a binding letter or intent has been duly executed by both parties no later than the "as of date" of the financial statement. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded. The reinsurance agreement must provide that:

(1) the agreement constitutes the entire agreement between the parties with respect to the business being reinsured under it and that there are no understandings between the parties other than as expressed in the agreement; and

(2) any change or modification to the agreement is null and void unless made by amendment to the agreement and signed by both parties.

Subd. 6. **Reserve credits.** Insurers subject to this section shall reduce to zero by December 31, 1995, any reserve credits or assets established with respect to reinsurance agreements entered into prior to August 1, 1994, that under the provisions of this section would not be entitled to recognition of the reserve credits

or assets; provided, however, that the reinsurance agreements have been in compliance with laws or regulations in existence immediately preceding August 1, 1994.

History: *1994 c 426 s 9*

INSURANCE REGULATORY INFORMATION SYSTEM

60A.90 SCOPE.

Sections 60A.90 to 60A.94 apply to all domestic, foreign, and alien insurers who are authorized to transact business in this state.

History: *1991 c 325 art 12 s 1*

60A.91 FILING REQUIREMENTS.

(a) A domestic, foreign, and alien insurer who is authorized to transact insurance in this state shall annually on or before March 1 of each year, file with the National Association of Insurance Commissioners (NAIC) a copy of its annual statement convention blank, along with additional filings prescribed by the commissioner for the preceding year. The information filed with the National Association of Insurance Commissioners must be in the same format and scope as that required by the commissioner and must include the signed jurat page and the actuarial certification. Amendments and addenda to the annual statement filing subsequently filed with the commissioner must also be filed with the NAIC.

(b) Foreign insurers that are domiciled in a state that has a law substantially similar to paragraph (a) is considered to be in compliance with this section.

History: *1991 c 325 art 12 s 2*

60A.92 IMMUNITY.

In the absence of actual malice, members of the NAIC, their duly authorized committees, subcommittees, and task forces, their delegates, NAIC employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks are acting as agents of the commissioner under the authority of sections 60A.90 to 60A.94 and are not subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required under sections 60A.90 to 60A.94.

History: *1991 c 325 art 12 s 3*

60A.93 CONFIDENTIALITY.

All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department.

History: *1991 c 325 art 12 s 4*

60A.94 REVOCATION OF CERTIFICATE OF AUTHORITY.

The commissioner may suspend, revoke, or refuse to renew the certificate of authority of an insurer failing to file its annual statement when due or within any extension of time that the commissioner, for good cause, may have granted.

History: *1991 c 325 art 12 s 5*

INSURANCE FRAUD

60A.951 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to sections 60A.951 to 60A.956.

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

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce for insurers regulated by the commissioner of commerce, and means the commissioner of health for insurers regulated by the commissioner of health.

Subd. 4. **Insurance fraud.** "Insurance fraud" occurs when a person presents or causes to be presented to any insurer, or prepares with knowledge or belief that it will be so presented, a written or oral statement, including a computer-generated document, an electronic claim filing, or other electronic transmission, that contains materially false or misleading information, or a material and misleading omission, concerning:

(1) an application for the issuance of an insurance policy;

(2) the rating of an insurance policy;

(3) a claim for payment, reimbursement, or benefits payable under an insurance policy to an insured, a beneficiary, or a third party;

(4) premiums on an insurance policy; or

(5) payments made in accordance with the terms of an insurance policy.

Subd. 4a. **Insurance policy or policy.** "Insurance policy" or "policy" means the written instrument in which are set forth the terms of any certificate of insurance, binder of coverage, or contract of insurance, including a certificate, binder, or contract issued by a state-assigned risk plan; benefit plan; nonprofit hospital service plan; motor club service plan; or surety bond, cash bond, or any other alternative to insurance authorized by the Minnesota Financial Responsibility Act.

Subd. 4b. **Insurance professional.** "Insurance professional" means sales agents, agencies, managing general agents, brokers, producers, claims representatives, adjusters, and third-party administrators.

Subd. 4c. **Insurance transaction.** "Insurance transaction" means a transaction by, between, or among:

(1) an insurer or a person who acts on behalf of an insurer; and

(2) an insured, claimant, applicant for insurance, public adjuster, insurance professional, practitioner who performs professional services as defined by section 319B.02, subdivision 19, attorney, or any person who acts on behalf of any of the foregoing for the purpose of obtaining insurance or reinsurance, calculating insurance premiums, submitting a claim, negotiating or adjusting a claim, or otherwise obtaining insurance, self-insurance, or reinsurance, or obtaining the benefits or annuities thereof or therefrom.

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

Subd. 5a. **Person.** "Person" means a natural person, company, corporation, unincorporated association, partnership, professional corporation, and any other entity.

Subd. 5b. **Premium.** "Premium" means consideration paid or payable for coverage under an insurance policy. Premium includes any payment, whether due within the insurance policy term or otherwise; any deductible payment, whether advanced by the insurer or insurance professional and subject to reimbursement by the insured or otherwise; any self-insured retention or payment, whether advanced by the insurer or insurance professional and subject to reimbursement by the insured or otherwise; and any collateral or security to be provided to collateralize any such obligations to pay.

Subd. 6. **Relevant information.** "Relevant information" includes, but is not limited to:

(1) pertinent insurance policy information, including the application for a policy;

(2) policy premium payment records;

(3) a history of previous claims made by the insured including, where the insured is a corporation, limited liability company, or partnership, a history of claims by a subsidiary or any affiliates, and a history of claims of any other business association in which individual officers or partners or their family members are known to be involved;

(4) material relating to the investigation, including the statement of any person and the proof of loss;

(5) billing records; and

(6) any other information which an authorized person identifies and which appears reasonably related to the investigation.

History: *1994 c 574 s 1; 1995 c 258 s 9,10; 1997 c 225 art 2 s 1; 2002 c 331 s 2-8; 2013 c 135 art 3 s 22; 2025 c 35 art 3 s 9*

60A.952 DISCLOSURE OF INFORMATION.

Subdivision 1. **Request.** After receiving a written request from an authorized person stating that the authorized person has reason to believe that a crime or civil fraud has been committed in connection with an insurance claim, insurance transaction, payment, or application, an insurer must release to the authorized person all relevant information in the insurer's possession.

Subd. 2. **Notice to and cooperation with the Bureau of Criminal Apprehension.** Any insurer or insurance professional that has reasonable belief that an act of insurance fraud will be, is being, or has been committed, shall furnish and disclose all relevant information to the Bureau of Criminal Apprehension or to any authorized person and cooperate fully with any investigation conducted by the Bureau of Criminal Apprehension. Any person that has a reasonable belief that an act of insurance fraud will be, is being, or has been committed, or any person who collects, reviews, or analyzes information concerning insurance fraud, may furnish and disclose any information in its possession concerning the act to the Bureau of Criminal Apprehension, any authorized person, or to an authorized representative of an insurer that requests the information for the purpose of detecting, prosecuting, or preventing insurance fraud. The insurer may also release relevant information to any person authorized to receive the information under section 72A.502, subdivision 2. If disclosure is made to an authorized person other than the Bureau of Criminal Apprehension, a copy of the disclosure must be sent to the Bureau of Criminal Apprehension.

Subd. 3. **Immunity from liability.** If insurers, insurance support organizations as defined in section 72A.491, subdivision 12, agents acting on the insurers' behalf, or authorized persons release information in good faith under this section, whether orally or in writing, they are immune from any liability, civil or criminal, for the release or reporting of the information.

Subd. 4. **Tolling of time periods.** If an insurer has a reasonable or probable cause to believe that an insurance fraud has been committed in connection with an insurance claim, and has properly notified the Bureau of Criminal Apprehension of its suspicions according to subdivision 2, the notification tolls any applicable time period in any unfair claims practices statute or related regulations, or any action on the claim against the insurer to whom the claim had been presented for bad faith, until 30 days after determination by the Bureau of Criminal Apprehension and notice to the insurer that the Bureau of Criminal Apprehension will not recommend action on the claim.

Subd. 5. **Reward for information.** The Bureau of Criminal Apprehension, in cooperation with authorized insurers and insurance professionals, may establish a voluntary fund to reward persons not connected with the insurance industry who provide information or furnish evidence leading to the arrest and conviction of persons responsible for insurance fraud.

History: *1994 c 574 s 2; 2002 c 331 s 9-12; 2013 c 135 art 3 s 22; 2014 c 310 s 2; 2025 c 35 art 3 s 10-12*

60A.953 ENFORCEMENT; REFUSAL TO COOPERATE WITH AN INVESTIGATION.

The intentional failure to provide relevant information as required by section 60A.952, subdivision 1, or to provide notification of insurance fraud as required by section 60A.952, subdivision 2, is punishable as a misdemeanor. It is unlawful for any person to knowingly or intentionally interfere with the enforcement of the provisions of sections 60A.951 to 60A.956 or investigation of suspected or actual violations of sections 60A.951 to 60A.956 and is punishable as a misdemeanor.

History: *1994 c 574 s 3; 2002 c 331 s 13*

60A.954 INSURANCE ANTIFRAUD PLAN.

Subdivision 1. **Establishment.** An insurer shall institute, implement, and maintain an antifraud plan. For the purpose of this section, the term insurer does not include reinsurers, the Workers' Compensation Reinsurance Association, self-insurers, and excess insurers. Within 30 days after instituting or materially modifying an antifraud plan, the insurer shall notify the commissioner in writing. The notice must include

the name of the person responsible for administering the plan. An antifraud plan shall establish procedures to:

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

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

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

Subd. 2. **Review.** The commissioner may review each insurer's antifraud plan to determine whether it complies with the requirements of this section. If the commissioner finds that an insurer's antifraud plan does not comply with the requirements of this section, the commissioner shall disapprove the plan and send a notice of disapproval, along with the reasons for disapproval, to the insurer. An insurer whose antifraud plan has been disapproved by the commissioner shall submit a new plan to the commissioner within 60 days after the plan was disapproved. The commissioner may examine an insurer's procedures to determine whether the insurer is complying with its antifraud plan. The commissioner shall withhold from public inspection any part of an insurer's antifraud plan for so long as the commissioner deems the withholding to be in the public interest. The commissioner may share an insurer's complete antifraud plan with the Bureau of Criminal Apprehension.

History: *1994 c 574 s 4; 1995 c 258 s 11; 2022 c 93 art 2 s 25; 2025 c 35 art 3 s 13*

60A.955 CLAIM FORMS TO CONTAIN FRAUD WARNING.

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

History: *1994 c 574 s 5; 1995 c 258 s 12*

60A.956 OTHER LAW ENFORCEMENT AUTHORITY.

Nothing in sections 60A.951 to 60A.956 preempts the authority of or relieves the duty of any other law enforcement agencies to investigate and prosecute alleged violations of law, prevents or prohibits a person from voluntarily disclosing any information concerning insurance fraud to any law enforcement agency other than the Bureau of Criminal Apprehension, or limits any of the powers granted elsewhere by the laws of this state to the commissioner of commerce to investigate alleged violations of law and to take appropriate action.

History: *2002 c 331 s 14; 2013 c 135 art 3 s 22; 2025 c 35 art 3 s 14*

VIATICAL SETTLEMENTS

60A.957 DEFINITIONS.

Subdivision 1. **Terms.** For purposes of sections 60A.957 to 60A.9585, the terms defined in this section have the meanings given them.

Subd. 2. **Advertising.** "Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public in this state, for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequeath, or transfer the death benefit or ownership of a life insurance policy pursuant to a viatical settlement contract.

Subd. 3. **Business of viatical settlements.** "Business of viatical settlements" means an activity involved in, but not limited to, the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner acquiring an interest in a life insurance policy by means of a viatical settlement contract.

Subd. 4. **Chronically ill.** "Chronically ill" means:

(1) being unable to perform at least two activities of daily living (for example, eating, toileting, transferring, bathing, dressing, or continence);

(2) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(3) having a level of disability similar to that described in clause (1) as determined by the United States Secretary of Health and Human Services.

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

Subd. 6. **Financing entity.** "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but:

(1) whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

(2) who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

Financing entity does not include a nonaccredited investor or a viatical settlement purchaser.

Subd. 7. **Fraudulent viatical settlement act.** "Fraudulent viatical settlement act" includes:

(a) acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:

(1) presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, viatical settlement investment agent, financing entity, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(i) an application for the issuance of a viatical settlement contract or insurance policy;

(ii) the underwriting of a viatical settlement contract or insurance policy;

(iii) a claim for payment or benefit pursuant to a viatical settlement contract or insurance policy;

(iv) premiums paid on an insurance policy or as a result of a viatical settlement purchase agreement;

(v) payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract, viatical settlement purchase agreement, or insurance policy;

(vi) the reinstatement or conversion of an insurance policy;

(vii) the solicitation, offer, effectuation, or sale of a viatical settlement contract, insurance policy, or viatical settlement purchase agreement;

(viii) the issuance of written evidence of viatical settlement contract, viatical settlement purchase agreement, or insurance; or

(ix) a financing transaction; and

(2) employing any plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies;

(b) acts or omissions in the furtherance of a fraud or to prevent the detection of a fraud committed by any person, its employees, or its agents, to:

(1) remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

(2) misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(3) transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

(4) file with the commissioner or the equivalent chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the commissioner;

(c) commit embezzlement, theft, misappropriation, or conversion of money, funds, premiums, credits, or other property of a viatical settlement provider, insurer, viator, insurance policyowner, or any other person engaged in the business of viatical settlements or insurance; or

(d) attempt to commit, assist, aid, or abet in the commission of, or conspiracy to commit, the acts or omissions specified in this subdivision.

Subd. 8. **Life insurance producer.** "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance pursuant to chapter 60K.

Subd. 9. **Person.** "Person" means a natural person or a legal entity, including, without limitation, an individual, partnership, limited liability company, association, trust, or corporation.

Subd. 10. **Policy.** "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

Subd. 11. **Related provider trust.** "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership

or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

Subd. 12. **Special purpose entity.** "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:

(1) for a financing entity or licensed viatical settlement provider; or

(2) in connection with a transaction in which:

(i) the securities in the special purpose entity are acquired by the viator or by "qualified institutional buyers" as defined in Rule 144 promulgated under the Securities Act of 1933, as amended; or

(ii) the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

Subd. 13. **Terminally ill.** "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

Subd. 14. **Viatical settlement broker.** "Viatical settlement broker" means a person, including a life insurance producer as provided in section 60A.9572, who, working exclusively on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or one or more viatical settlement brokers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interests of the viator. Viatical settlement broker does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

Subd. 15. **Viatical settlement contract.** (a) "Viatical settlement contract" means a written agreement between a viator and a viatical settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the policy, in return for the viator's present or future assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. Viatical settlement contract also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such a policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract insures the life of a person residing in this state.

(b) Viatical settlement contract includes a premium finance loan made for a life insurance policy by a lender to a viator on, before, or after the date of issuance of the policy where:

(1) the viator or the insured receives on the date of the premium finance loan a guarantee of a future viatical settlement value of the policy; or

(2) the viator or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(c) Viatical settlement contract does not include:

(1) a policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms;

(2) loan proceeds that are used solely to pay:

(i) premiums for the policy; and

(ii) the costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(3) a loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of a policy by the lender, provided that neither the default itself nor the transfer of the policy in connection with the default is pursuant to an agreement or understanding with any other person for the purposes of evading regulation under sections 60A.957 to 60A.9585;

(4) a loan made by a lender that does not violate chapter 59A, provided that the premium finance loan is not described in clause (3);

(5) an agreement where all the parties (i) are closely related to the insured by blood or law or (ii) have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured, or are trusts established primarily for the benefit of the parties;

(6) any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(7) a bona fide business succession planning arrangement:

(i) between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders;

(ii) between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners; or

(iii) between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members;

(8) an agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(9) any other contract, transaction, or arrangement exempted from the definition of viatical settlement contract by the commissioner based on a determination that the contract, transaction, or arrangement is not of the type intended to be regulated by sections 60A.957 to 60A.9585.

Subd. 16. **Viatical settlement investment agent.** (a) "Viatical settlement investment agent" means a person who is an appointed or contracted agent of a licensed viatical settlement provider who solicits or

arranges the funding for the purchase of a viatical settlement by a viatical settlement purchaser and who is acting on behalf of a viatical settlement provider.

(b) A viatical settlement investment agent shall not have any contact directly or indirectly with the viator or insured or have knowledge of the identity of the viator or insured.

(c) A viatical settlement investment agent is deemed to represent the viatical settlement provider of whom the viatical settlement investment agent is an appointed or contracted agent.

Subd. 17. **Viatical settlement provider.** (a) "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract with a viator resident in this state.

(b) Viatical settlement provider does not include:

(1) a bank, savings bank, savings and loan association, credit union, or other licensed lending institution;

(2) a premium finance company making premium finance loans and exempted by the commissioner from the licensing requirement under the premium finance laws that takes an assignment of a life insurance policy solely as collateral for a loan;

(3) the issuer of the life insurance policy;

(4) an authorized or eligible insurer that provides stop-loss coverage or financial guaranty insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

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

(6) a financing entity;

(7) a special purpose entity;

(8) a related provider trust;

(9) a viatical settlement purchaser; or

(10) any other person that the commissioner determines is not the type of person intended to be covered by the definition of viatical settlement provider.

Subd. 18. **Viatical settlement purchase agreement.** "Viatical settlement purchase agreement" means a contract or agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit.

Subd. 19. **Viatical settlement purchaser.** (a) "Viatical settlement purchaser" means a person who provides a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit.

(b) Viatical settlement purchaser does not include:

(1) a licensee under sections 60A.957 to 60A.9585;

(2) an accredited investor or qualified institutional buyer as defined, respectively, in Rule 501(a) or Rule 144A promulgated under the federal Securities Act of 1933, as amended;

(3) a financing entity;

(4) a special purpose entity; or

(5) a related provider trust.

Subd. 20. **Viaticated policy.** "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

Subd. 21. **Viator.** (a) "Viator" means the owner of a life insurance policy or a certificate holder under a group policy that resides in this state and enters or seeks to enter into a viatical settlement contract. For purposes of sections 60A.957 to 60A.9585, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. If there is more than one viator on a single policy and the viators are residents of different states, the transaction is governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all the viators.

(b) Viator does not include:

(1) a licensee under sections 60A.957 to 60A.9585, including a life insurance producer acting as a viatical settlement broker pursuant to sections 60A.957 to 60A.9585;

(2) a qualified institutional buyer as defined in Rule 144A promulgated under the federal Securities Act of 1933, as amended;

(3) a financing entity;

(4) a special purpose entity; or

(5) a related provider trust.

History: *2009 c 62 s 2*

60A.9572 LICENSE AND BOND REQUIREMENTS.

Subdivision 1. **Provider or broker license required.** A person shall not operate as a viatical settlement provider or viatical settlement broker in this state without first obtaining a license from the commissioner of the state of residence of the viator.

Subd. 2. **Agent license required.** A person shall not operate as a viatical settlement investment agent in this state without first obtaining a license from the commissioner of the state of residence of the viatical settlement purchaser. If there is more than one purchaser of a single policy and the purchasers are residents of different states, the viatical settlement purchase agreement shall be governed by the law of the state in which the purchaser having the largest percentage ownership resides or, if the purchasers hold equal ownership, the state of residence of one purchaser agreed upon in writing by all purchasers.

Subd. 3. **Life insurance producer.** (a) An insurance producer who is currently licensed with the life line of authority and has been licensed in good standing for at least one year is deemed to meet the licensing requirements of this section and is permitted to operate as a viatical settlement broker.

(b) Not later than 30 days from the first day of operating as a viatical settlement broker, the life insurance producer shall notify the commissioner that the life insurance producer is acting as a viatical settlement broker on a form prescribed by the commissioner, and shall pay any applicable fee to be determined by the commissioner. Notification includes an acknowledgment by the life insurance producer that the life insurance producer will operate as a viatical settlement broker in accordance with sections 60A.957 to 60A.9585.

(c) The insurer that issued the policy being viaticated is not responsible for any act or omission of a viatical settlement broker or viatical settlement provider arising out of or in connection with the viatical settlement transaction, unless the insurer receives compensation for the placement of a viatical settlement contract from the viatical settlement provider or viatical settlement broker in connection with the viatical settlement contract.

(d) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator, whose compensation is not paid directly or indirectly by the viatical settlement provider, may negotiate viatical settlement contracts on behalf of the viator without having to obtain a license as a viatical settlement broker.

Subd. 4. **Application.** An application for a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent license shall be made to the commissioner by the applicant on a form prescribed by the commissioner, and these applications shall be accompanied by the fees specified in section 60A.964.

Subd. 5. **Renewals.** A license may be renewed from year to year on the anniversary date upon payment of the annual renewal fees specified in section 60A.964. Failure to pay the fees by the renewal date results in expiration of the license.

Subd. 6. **Disclosures.** The applicant shall provide information on forms required by the commissioner. The commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders who hold more than ten percent of the shares of the company, partners, officers, members, and employees, and the commissioner may, in the exercise of the commissioner's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner, or member of the legal entity who may materially influence the applicant's conduct meets the standards of sections 60A.957 to 60A.9585.

Subd. 7. **Legal entity license.** A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers, viatical settlement brokers, or viatical settlement investment agents, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

Subd. 8. **Investigation.** Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and issue a license if the commissioner finds that the applicant:

(1) if a viatical settlement provider, has provided a detailed plan of operation;

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

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

(4) if a viatical settlement provider or a viatical settlement broker, has demonstrated evidence of financial responsibility in a format prescribed by the commissioner through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or a deposit of cash, certificates of deposit, or securities or any combination thereof in an amount to be determined by the commissioner. The commissioner shall accept, as evidence of financial responsibility, proof that financial instruments in accordance with the requirements in this clause have been filed with one or more states where the applicant is licensed as a viatical settlement provider or a viatical settlement broker. The commissioner may ask for evidence of financial responsibility at any time the commissioner deems necessary. Any surety bond issued pursuant to this clause shall be in favor of this state and shall specifically authorize recovery by the commissioner on behalf of any person in this state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices by the viatical settlement provider or a viatical settlement broker;

(5) if a legal entity, provides a certificate of good standing from the state of its domicile; and

(6) if a viatical settlement provider or viatical settlement broker, has provided an antifraud plan that meets the requirements of section 60A.9583.

Subd. 9. **Consent to service of process.** The commissioner shall not issue a license to a nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the commissioner or the applicant has filed with the commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

Subd. 10. **Duty to supplement information.** A viatical settlement provider, viatical settlement broker, or viatical settlement investment agent shall provide to the commissioner new or revised information about officers, ten percent or more stockholders, partners, directors, members, or designated employees within 30 days of the change.

Subd. 11. **Training required.** An individual licensed as a viatical settlement broker shall complete on an annual basis six hours of training related to viatical settlements and viatical settlement transactions, as required by the commissioner; provided, however, that a life insurance producer who is operating as a viatical settlement broker pursuant to subdivision 3 shall not be subject to the requirements of this subdivision. Any person failing to meet the requirements of this subdivision is subject to the penalties imposed by the commissioner.

History: *2009 c 62 s 3; 2010 c 384 s 11*

60A.9573 LICENSE REVOCATION AND DENIAL.

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

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

(2) the licensee or any officer, partner, member, or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent;

(3) the viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(4) the licensee or any officer, partner, member, or key management personnel has been found guilty of, or has pleaded guilty or nolo contendere to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(5) the viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to sections 60A.957 to 60A.9585;

(6) the viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract or a viatical settlement purchase agreement;

(7) the licensee no longer meets the requirements for initial licensure;

(8) the viatical settlement provider has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state, a viatical settlement purchaser, an accredited investor or qualified institutional buyer as defined respectively in Rule 501(a) or Rule 144A promulgated under the federal Securities Act of 1933, as amended, a financing entity, a special purpose entity, or a related provider trust; or

(9) the licensee or any officer, partner, member, or key management personnel has violated any provision of sections 60A.957 to 60A.9585.

Subd. 2. **Bad faith by broker or producer.** The commissioner may suspend, revoke, or refuse to renew the license of a viatical settlement broker or a life insurance producer operating as a viatical settlement broker pursuant to sections 60A.957 to 60A.9585 if the commissioner finds that the viatical settlement broker or life insurance producer has violated the provisions of sections 60A.957 to 60A.9585 or has otherwise engaged in bad faith conduct with one or more viators.

Subd. 3. **License enforcement actions.** Section 45.027 applies to any action taken by the commissioner to deny a license application or suspend, revoke, or refuse to renew the license of a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent, or suspend, revoke, or refuse to renew a license of a life insurance producer operating as a viatical settlement broker pursuant to sections 60A.957 to 60A.9585.

History: *2009 c 62 s 4*

60A.9574 APPROVAL OF VIATICAL SETTLEMENT CONTRACTS AND DISCLOSURE STATEMENTS.

A person shall not use a viatical settlement contract form or provide to a viator a disclosure statement form in this state unless first filed with and approved by the commissioner. The commissioner shall disapprove a viatical settlement contract form or disclosure statement form if, in the commissioner's opinion, the contract or provisions fail to meet the requirements of sections 60A.9577, 60A.9579, 60A.9582, and 60A.9583, subdivision 2, or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator. At the commissioner's discretion, the commissioner may require the submission of advertising material.

History: *2009 c 62 s 5*

60A.9575 REPORTING REQUIREMENTS AND PRIVACY.

Subdivision 1. **Annual statement.** A viatical settlement provider shall file with the commissioner on or before March 1 of each year an annual statement containing the following information:

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

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

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

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

(5) the portfolio size; and

(6) the amount of outside borrowings.

The information shall be limited to only those transactions where the viator is a resident of this state. Individual transaction data regarding the business of viatical settlements or data that could compromise the privacy of personal, financial, and health information of the viator or insured shall be filed with the commissioner on a confidential basis.

Subd. 2. **Identity disclosure restrictions.** Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure:

(1) is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(2) is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(3) is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to section 45.027;

(4) is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

(5) is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(6) is necessary to allow a viatical settlement provider or viatical settlement broker or an authorized representative to make contacts for the purpose of determining health status; or

(7) is required to purchase stop-loss coverage or financial guaranty insurance.

History: *2009 c 62 s 6*

60A.9577 DISCLOSURE TO VIATOR.

Subdivision 1. **Application disclosures by provider and broker.** With an application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least

the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall provide the following information:

(1) that a viatical settlement broker represents exclusively the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interests of the viator;

(2) some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor;

(3) proceeds of the viatical settlement could be subject to the claims of creditors;

(4) receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies;

(5) the viator has the right to rescind a viatical settlement contract before the earlier of 30 calendar days after the date upon which the viatical settlement contract is executed by all parties or 15 calendar days after the viatical settlement proceeds have been paid to the viator, as provided in section 60A.9579, subdivision 3. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given, and the viator repays all proceeds and any premiums, loans, and loan interest paid on account of the viatical settlement within the rescission period. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment by the viator or the viator's estate of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement within 60 days of the insured's death;

(6) funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated;

(7) entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser;

(8) the disclosure document shall contain the following language: "All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."; and

(9) following execution of a viatical contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in sections 60A.957 to 60A.9585. This contact shall be limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less. Contacts shall be made only by a viatical settlement provider licensed in the state in which the viator resided at the time of the viatical settlement, or by the authorized representative of a duly licensed viatical settlement provider.

Disclosure to a viator under this subdivision includes distribution of a brochure describing the process of viatical settlements. The National Association of Insurance Commissioners form for the brochure shall be used unless another form is developed or approved by the commissioner.

Subd. 2. **Contract disclosures by provider.** A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(1) the affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

(2) the document includes the name, business address, and telephone number of the viatical settlement provider;

(3) any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement broker;

(4) if an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with the viator's insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement;

(5) state the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract; and

(6) state whether the funds will be escrowed with an independent third party during the transfer process, and if so, provide the name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

Subd. 3. **Contract disclosures by broker.** A viatical settlement broker shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(1) the name, business address, and telephone number of the viatical settlement broker;

(2) a full, complete, and accurate description of all offers, counteroffers, acceptances, and rejections relating to the proposed viatical settlement contract;

(3) a written disclosure of any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contracts;

(4) the name of each broker who receives compensation and the amount of compensation received by that broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract; and

(5) where any portion of the viatical settlement broker's compensation, as defined in clause (4), is taken from a proposed viatical settlement offer, the broker shall also disclose the total amount of the viatical

settlement offer and the percentage of the viatical settlement offer comprised by the viatical settlement broker's compensation.

Subd. 4. **Ownership and beneficiary changes.** If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within 20 days after the change.

Subd. 5. **Contract disclosures by provider or agent.** A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures prior to the date the viatical settlement purchase agreement is signed by all parties. The disclosures shall be conspicuously displayed in any viatical purchase contract or in a separate document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosures to the viatical settlement purchaser:

(1) the purchaser will receive no returns, for example, dividends and interest, until the insured dies and a death claim payment is made;

(2) the actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual guaranteed rate of return is not determinable;

(3) the viaticated life insurance contract should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds are probably not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser;

(4) the purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment;

(5) the purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party shall also be disclosed;

(6) the purchaser is responsible for payment of the insurance premiums or other costs related to the policy if the insured returns to health. Disclose the amount of the premiums, if applicable;

(7) the name, business address, and telephone number of the independent third party providing escrow services and the relationship to the broker;

(8) the amount of any trust fees or other expenses to be charged to the viatical settlement purchaser shall be disclosed;

(9) whether the purchaser is entitled to a refund of all or part of the purchaser's investment under the settlement contract if the policy is later determined to be null and void;

(10) that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage;

(11) the risks associated with policy contestability including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period;

(12) whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid; and

(13) the experience and qualifications of the person who determines the life expectancy of the insured, for example, in-house staff, independent physicians, and specialty firms that weigh medical and actuarial data; the information this projection is based on; and the relationship of the projection maker to the viatical settlement provider, if any.

Disclosure to a viatical settlement purchaser under this subdivision includes the distribution of a brochure describing the process of investment in viatical settlements. The National Association of Insurance Commissioners form for the brochure shall be used unless one is developed by the commissioner.

Subd. 6. **Transfer or sale disclosures by provider or agent.** A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer, or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosures to the viatical settlement purchaser:

(1) disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator;

(2) state whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums;

(3) state whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums;

(4) disclose the type of policy offered or sold, for example, whole life, term life, universal life, or a group policy certificate; any additional benefits contained in the policy; and the current status of the policy;

(5) if the policy is term insurance, disclose the special risks associated with term insurance including, but not limited to, the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term;

(6) state whether the policy is contestable;

(7) state whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are, and under what conditions these rights are activated; and

(8) state the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchaser.

Subd. 7. **Agreement voidable.** The viatical settlement purchase agreement is voidable by the purchaser at any time within three days after the disclosures mandated by subdivisions 4 and 5 are received by the purchaser.

History: *2009 c 62 s 7*

60A.9579 GENERAL RULES.

Subdivision 1. **Provider requirements.** (a) A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(1) if the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(2) a document in which the insured consents to the release of the insured's medical records to a licensed viatical settlement provider, viatical settlement broker, and the insurance company that issued the life insurance policy covering the life of the insured.

(b) Within 20 days after a viator executes documents necessary to transfer any rights under an insurance policy or within 20 days of entering any agreement, option, promise, or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by paragraph (c).

(c) The viatical provider shall deliver a copy of the medical release required under paragraph (a), clause (2), a copy of the viator's application for the viatical settlement contract, the notice required under paragraph (b), and a request for verification of coverage to the insurer that issued the life insurance policy that is the subject of the viatical transaction. The National Association of Insurance Commissioners form for verification of coverage shall be used unless another form is developed or approved by the commissioner.

(d) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within 30 calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on a National Association of Insurance Commissioners form or any other form approved by the commissioner. The insurer shall accept an original or facsimile or electronic copy of a request and any accompanying authorization signed by the viator. Failure by the insurer to meet its obligations under this subdivision is a violation of sections 60A.9581, subdivision 3, and 60A.9585.

(e) Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that the viator has a full and complete understanding of the benefits of the life insurance policy, acknowledges that the viator is entering into the viatical settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(f) If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

Subd. 2. **Confidentiality of personal information.** All personal information solicited or obtained by any licensee shall be subject to sections 72A.49 to 72A.505.

Subd. 3. **General right of rescission.** A viatical settlement contract entered into in this state shall provide the viator with an absolute right to rescind the contract before the earlier of 30 calendar days after the date upon which the viatical settlement contract is executed by all parties or 15 calendar days after the viatical settlement proceeds have been sent to the viator as provided in subdivision 6. Rescission by the viator may be conditioned upon the viator both giving notice and repaying to the viatical settlement provider within the rescission period all proceeds of the settlement and any premiums, loans, and loan interest paid by or on behalf of the viatical settlement provider in connection with or as a consequence of the viatical settlement. If the insured dies during the rescission period, the viatical settlement contract is deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser, which shall be paid within 60 calendar days of the death of the insured. In the event of any rescission, if the viatical settlement provider has paid commissions or other compensation to a viatical settlement broker in connection with the rescinded transaction, the viatical settlement broker shall refund all commissions and compensation to the viatical settlement provider within five business days following receipt of written demand from the viatical settlement provider, which demand shall be accompanied by either the viator's notice of rescission if rescinded at the election of the viator, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

Subd. 4. **Right to rescind after mandated disclosures.** The purchaser shall have the right to rescind a viatical settlement contract within three days after the disclosures mandated by section 60A.9577, subdivisions 5 and 6, are received by the purchaser.

Subd. 5. **Payment of settlement proceeds.** The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow agent. Within three business days after the date the escrow agent receives the document, or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state- or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or related provider trust or other designated representative of the viatical settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

Subd. 6. **Tendering consideration.** Failure to tender consideration to the viator for the viatical settlement contract within the time set forth in the disclosure pursuant to section 60A.9577, subdivision 1, clause (6), renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator. Funds shall be deemed sent by a viatical settlement provider to a viator as of the date that the escrow agent either releases funds for wire transfer to the viator or places a check for delivery to the viator by United States mail or other nationally recognized delivery service.

Subd. 7. **Health status contacts.** Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or broker licensed in this state or its authorized representatives and shall be limited to once every three months for insureds with a life expectancy

of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations in this subdivision shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

History: *2009 c 62 s 8*

60A.9581 PROHIBITED PRACTICES AND CONFLICTS OF INTEREST.

Subdivision 1. **Solicitations and sales to controlled person.** With respect to any viatical settlement contract or insurance policy, no viatical settlement broker knowingly shall solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, viatical settlement purchaser, viatical settlement investment agent, financing entity, or related provider trust that is controlling, controlled by, or under common control with the viatical settlement broker unless this relationship is disclosed to the viator.

Subd. 2. **Payment to controlled broker.** With respect to any viatical settlement contract or insurance policy, no viatical settlement provider knowingly may enter into a viatical settlement contract with a viator, if, in connection with a viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with the viatical settlement provider or the viatical settlement purchaser, viatical settlement investment agent, financing entity, or related provider trust that is involved in a viatical settlement contract unless this relationship is disclosed to the viator.

Subd. 3. **Fraudulent viatical settlement act.** A violation of subdivisions 1 and 2 is deemed a fraudulent viatical settlement act.

Subd. 4. **Advertising.** (a) No viatical settlement provider shall enter into a viatical settlement contract unless the viatical settlement promotional, advertising, and marketing materials, as may be prescribed by rule, have been filed with the commissioner. In no event shall any marketing materials expressly reference that the insurance is "free" for any period of time. The inclusion of any reference in the marketing materials that would cause a viator to reasonably believe that the insurance is free for any period of time shall be considered a violation of sections 60A.957 to 60A.9585.

(b) No life insurance producer, insurance company, viatical settlement broker, viatical settlement provider, or viatical settlement investment agent shall make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

History: *2009 c 62 s 9*

60A.9582 ADVERTISING FOR VIATICAL SETTLEMENTS AND VIATICAL SETTLEMENTS PURCHASE AGREEMENTS.

Subdivision 1. **Application.** This section applies to any advertising of viatical settlement contracts, viatical purchase agreements, or related products or services intended for dissemination in this state, including Internet advertising viewed by persons located in this state. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

Subd. 2. **System of control.** Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts,

products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the viatical settlement licensees, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the viatical settlement licensee.

Subd. 3. **Form and content.** Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract or viatical settlement purchase agreement, product, or service shall be sufficiently complete and clear so as to avoid deception and it shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

Subd. 4. **False and misleading advertisements.** Certain viatical settlement advertisements are deemed false and misleading on their face and are prohibited. False and misleading viatical settlement advertisements include, but are not limited to, the following representations:

(1) "guaranteed," "fully secured," "100 percent secured," "fully insured," "secure," "safe," "backed by rated insurance companies," "backed by federal law," "backed by state law," "state guaranty funds," or similar representations;

(2) "no risk," "minimal risk," "low risk," "no speculation," "no fluctuation," or similar representations;

(3) "qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers," "tax deferred," or similar representations;

(4) utilization of the word "guaranteed" to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;

(5) "no sales charges or fees" or similar representations;

(6) "high yield," "superior return," "excellent return," "high return," "quick profit," or similar representations; and

(7) purported favorable representations or testimonials about the benefits of viatical settlement contracts or viatical settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and television programs, and all other forms of print and electronic media.

Subd. 5. **Disclosures regulated.** (a) The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(b) An advertisement shall not omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators, purchasers, or prospective purchasers as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the viatical settlement contract or viatical settlement purchase agreement offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract or viatical settlement

purchase agreement includes a "free look" period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(c) An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

(d) An advertisement shall not represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement contract or viatical settlement purchase agreement in order to maintain that policy, unless that is the fact.

(e) An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(f) The words "free," "no cost," "without cost," "no additional cost," "at no extra cost," or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(g) Testimonials, appraisals, or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract or viatical settlement purchase agreement product or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators or purchasers as to the nature or scope of the testimonials, appraisal, analysis, or endorsement. In using testimonials, appraisals, or analysis, a licensee under sections 60A.957 to 60A.9585 makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(h) If the individual making a testimonial, appraisal, analysis, or endorsement has a financial interest in the party making use of the testimonial, appraisal, analysis, or endorsement, either directly or through a related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union-scale wages, that fact shall be prominently disclosed in the advertisement.

(i) An advertisement shall not state or imply that a viatical settlement contract or viatical settlement purchase agreement, benefit, or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(j) When an endorsement refers to benefits received under a viatical settlement contract or viatical settlement purchase agreement, all pertinent information shall be retained for a period of five years after its use.

Subd. 6. **Statistics.** An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

Subd. 7. **Disparaging advertisements.** An advertisement shall not disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services, or methods of marketing.

Subd. 8. **Licensee's name.** The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract or viatical settlement purchase agreements,

products, or services, and if any specific viatical settlement contract or viatical settlement purchase agreement is advertised, the viatical settlement contract or viatical settlement purchase agreement shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

Subd. 9. **Licensee disclosure.** An advertisement shall not use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract or viatical settlement purchase agreement.

Subd. 10. **Government sponsorship; misleading advertisements.** An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

Subd. 11. **State licensure.** An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that a competing viatical settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's website or contact the Department of Commerce to find out if the state requires licensing and, if so, whether the viatical settlement provider, viatical settlement broker, or viatical settlement investment agent is licensed.

Subd. 12. **Government entity endorsement.** An advertisement shall not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its viatical settlement contracts or viatical settlement purchase agreement forms are recommended or endorsed by any government entity.

Subd. 13. **Name.** The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

Subd. 14. **Government approval.** An advertisement shall not directly or indirectly create the impression that any division or agency of the state or of the United States government endorses, approves, or favors:

(1) any viatical settlement licensee or its business practices or methods of operation;

(2) the merits, desirability, or advisability of any viatical settlement contract or viatical settlement purchase agreement;

(3) any viatical settlement contract or viatical settlement purchase agreement; or

(4) any life insurance policy or life insurance company.

Subd. 15. **Time frame disclosure.** If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

Subd. 16. **Average purchase price.** If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

History: *2009 c 62 s 10*

60A.9583 FRAUD PREVENTION AND CONTROL.

Subdivision 1. **Fraudulent viatical settlement acts, interference, and participation of convicted felons prohibited.** (a) A person who commits a fraudulent viatical settlement act commits insurance fraud and may be sentenced under section 609.611, subdivision 3.

(b) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of sections 60A.957 to 60A.9585 or investigations of suspected or actual violations of sections 60A.957 to 60A.9585.

(c) A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

Subd. 2. **Fraud warning required.** (a) Viatical settlements contracts and purchase agreement forms and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement: "Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a crime and may be subject to fines and confinement in prison."

(b) The lack of a statement as required in paragraph (a) does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

Subd. 3. **Mandatory reporting of fraudulent viatical settlement acts.** Any person engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the commissioner such information as required by, and in a manner prescribed by, the commissioner.

Subd. 4. **Viatical settlement antifraud initiatives.** (a) Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. At the discretion of the commissioner, the commissioner may order, or a licensee may request and the commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

(b) Antifraud initiatives shall include:

(1) fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(2) an antifraud plan, which shall be submitted to the commissioner. The antifraud plan shall include, but not be limited to:

(i) a description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(ii) a description of the procedures for reporting possible fraudulent viatical settlement acts to the commissioner;

(iii) a description of the plan for antifraud education and training of underwriters and other personnel; and

(iv) a description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(c) Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

History: *2009 c 62 s 11*

60A.9585 UNFAIR TRADE PRACTICE.

A violation of sections 60A.957 to 60A.9585, including the commission of a fraudulent viatical settlement act, shall be considered an unfair trade practice under section 72A.20.

History: *2009 c 62 s 12*

60A.961 [Repealed, 2009 c 62 s 14]

60A.962 [Repealed, 2009 c 62 s 14]

60A.963 [Repealed, 2009 c 62 s 14]

60A.964 FEES.

Subdivision 1. **Amount.** The licensing fee for a viatical settlement provider, viatical settlement broker, or viatical settlement investment agent license is $750 for initial licensure and $250 for each annual renewal. The fees must be limited to the cost of license administration and enforcement and must be deposited in the state treasury, credited to a special account, and appropriated to the commissioner.

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

History: *1995 c 151 s 5; 1999 c 250 art 3 s 6; 2009 c 62 s 13*

60A.965 [Repealed, 2009 c 62 s 14]

60A.966 [Repealed, 2009 c 62 s 14]

60A.967 [Repealed, 2009 c 62 s 14]

60A.968 [Repealed, 2009 c 62 s 14]

60A.969 [Repealed, 2009 c 62 s 14]

60A.970 [Repealed, 2009 c 62 s 14]

60A.971 [Repealed, 2009 c 62 s 14]

60A.972 [Repealed, 2009 c 62 s 14]

60A.973 [Repealed, 2009 c 62 s 14]

60A.974 [Repealed, 2009 c 62 s 14]

STRUCTURED SETTLEMENT ANNUITIES

60A.975 DEFINITIONS.

Subdivision 1. **Application.** For purposes of sections 60A.975 and 60A.976, the definitions in this section have the meanings given them.

Subd. 2. **Annuity issuer.** "Annuity issuer" means an insurer that issues an insurance contract used to fund periodic payments under a structured settlement agreement.

Subd. 3. **Structured settlement.** "Structured settlement" means an arrangement for periodic payment of damages entered on behalf of a minor or incompetent person for personal injuries established by settlement or judgment.

Subd. 4. **Structured settlement agreement.** "Structured settlement agreement" means the agreement, judgment, stipulation, or release embodying the terms of a structured settlement.

History: *2001 c 131 s 4*

60A.976 ANNUITY ISSUERS FINANCIAL REQUIREMENTS.

An annuity purchased to finance a structured settlement agreement may be purchased only from an annuity issuer with a financial rating equivalent to A.M. Best Company A+ Class 8 or better; or a Standard & Poor's AA or better.

History: *2001 c 131 s 5*

INFORMATION SECURITY PROGRAM

60A.98 MS 2020 [Repealed, 1Sp2021 c 4 art 3 s 29]

60A.981 MS 2020 [Repealed, 1Sp2021 c 4 art 3 s 29]

60A.982 MS 2020 [Repealed, 1Sp2021 c 4 art 3 s 29]

60A.985 DEFINITIONS.

Subdivision 1. **Terms.** As used in sections 60A.985 to 60A.9857, the following terms have the meanings given.

Subd. 2. **Authorized individual.** "Authorized individual" means an individual known to and screened by the licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and its information systems.

Subd. 3. **Consumer.** "Consumer" means an individual, including but not limited to an applicant, policyholder, insured, beneficiary, claimant, and certificate holder who is a resident of this state and whose nonpublic information is in a licensee's possession, custody, or control.

Subd. 4. **Cybersecurity event.** "Cybersecurity event" means an event resulting in unauthorized access to, or disruption or misuse of, an information system or nonpublic information stored on an information system.

Cybersecurity event does not include the unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization.

Cybersecurity event does not include an event with regard to which the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

Subd. 5. **Encrypted.** "Encrypted" means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key.

Subd. 6. **Information security program.** "Information security program" means the administrative, technical, and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information.

Subd. 7. **Information system.** "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of nonpublic electronic information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

Subd. 8. **Licensee.** "Licensee" means any person licensed, authorized to operate, or registered, or required to be licensed, authorized, or registered by the Department of Commerce or the Department of Health under chapters 59A to 62M, 62Q to 62V, and 64B to 79A.

Subd. 9. **Multifactor authentication.** "Multifactor authentication" means authentication through verification of at least two of the following types of authentication factors:

(1) knowledge factors, such as a password;

(2) possession factors, such as a token or text message on a mobile phone; or

(3) inherence factors, such as a biometric characteristic.

Subd. 10. **Nonpublic information.** "Nonpublic information" means electronic information that is not publicly available information and is:

(1) any information concerning a consumer which because of name, number, personal mark, or other identifier can be used to identify the consumer, in combination with any one or more of the following data elements:

(i) Social Security number;

(ii) driver's license number or nondriver identification card number;

(iii) financial account number, credit card number, or debit card number;

(iv) any security code, access code, or password that would permit access to a consumer's financial account; or

(v) biometric records; or

(2) any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer that can be used to identify a particular consumer and that relates to:

(i) the past, present, or future physical, mental, or behavioral health or condition of any consumer or a member of the consumer's family;

(ii) the provision of health care to any consumer; or

(iii) payment for the provision of health care to any consumer.

Subd. 11. **Person.** "Person" means any individual or any nongovernmental entity, including but not limited to any nongovernmental partnership, corporation, branch, agency, or association.

Subd. 12. **Publicly available information.** "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from: federal, state, or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state, or local law.

For the purposes of this definition, a licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(1) that the information is of the type that is available to the general public; and

(2) whether a consumer can direct that the information not be made available to the general public and, if so, that such consumer has not done so.

Subd. 13. **Risk assessment.** "Risk assessment" means the risk assessment that each licensee is required to conduct under section 60A.9851, subdivision 3.

Subd. 14. **State.** "State" means the state of Minnesota.

Subd. 15. **Third-party service provider.** "Third-party service provider" means a person, not otherwise defined as a licensee, that contracts with a licensee to maintain, process, or store nonpublic information, or is otherwise permitted access to nonpublic information through its provision of services to the licensee.

History: *1Sp2021 c 4 art 3 s 5; 2022 c 55 art 1 s 14*

60A.9851 INFORMATION SECURITY PROGRAM.

Subdivision 1. **Implementation of an information security program.** Commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control, each licensee shall develop, implement, and maintain a comprehensive written information security program based on the licensee's risk assessment and that contains administrative, technical, and physical safeguards for the protection of nonpublic information and the licensee's information system.

Subd. 2. **Objectives of an information security program.** A licensee's information security program shall be designed to:

(1) protect the security and confidentiality of nonpublic information and the security of the information system;

(2) protect against any threats or hazards to the security or integrity of nonpublic information and the information system;

(3) protect against unauthorized access to, or use of, nonpublic information, and minimize the likelihood of harm to any consumer; and

(4) define and periodically reevaluate a schedule for retention of nonpublic information and a mechanism for its destruction when no longer needed.

Subd. 3. **Risk assessment.** The licensee shall:

(1) designate one or more employees, an affiliate, or an outside vendor authorized to act on behalf of the licensee who is responsible for the information security program;

(2) identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration, or destruction of nonpublic information, including threats to the security of information systems and nonpublic information that are accessible to, or held by, third-party service providers;

(3) assess the likelihood and potential damage of the threats identified pursuant to clause (2), taking into consideration the sensitivity of the nonpublic information;

(4) assess the sufficiency of policies, procedures, information systems, and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the licensee's operations, including:

(i) employee training and management;

(ii) information systems, including network and software design, as well as information classification, governance, processing, storage, transmission, and disposal; and

(iii) detecting, preventing, and responding to attacks, intrusions, or other systems failures; and

(5) implement information safeguards to manage the threats identified in its ongoing assessment, and no less than annually, assess the effectiveness of the safeguards' key controls, systems, and procedures.

Subd. 4. **Risk management.** Based on its risk assessment, the licensee shall:

(1) design its information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control;

(2) determine which of the following security measures are appropriate and implement any appropriate security measures:

(i) place access controls on information systems, including controls to authenticate and permit access only to authorized individuals, to protect against the unauthorized acquisition of nonpublic information;

(ii) identify and manage the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization's risk strategy;

(iii) restrict physical access to nonpublic information to authorized individuals only;

(iv) protect, by encryption or other appropriate means, all nonpublic information while being transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media;

(v) adopt secure development practices for in-house developed applications utilized by the licensee;

(vi) modify the information system in accordance with the licensee's information security program;

(vii) utilize effective controls, which may include multifactor authentication procedures for any authorized individual accessing nonpublic information;

(viii) regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems;

(ix) include audit trails within the information security program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee;

(x) implement measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage, other catastrophes, or technological failures; and

(xi) develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format;

(3) include cybersecurity risks in the licensee's enterprise risk management process;

(4) stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared; and

(5) provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment.

Subd. 5. **Oversight by board of directors.** If the licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum:

(1) require the licensee's executive management or its delegates to develop, implement, and maintain the licensee's information security program;

(2) require the licensee's executive management or its delegates to report in writing, at least annually, the following information:

(i) the overall status of the information security program and the licensee's compliance with sections 60A.985 to 60A.9858; and

(ii) material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, cybersecurity events or violations and management's responses thereto, and recommendations for changes in the information security program; and

(3) if executive management delegates any of its responsibilities under this section, it shall oversee the development, implementation, and maintenance of the licensee's information security program prepared by the delegate and shall receive a report from the delegate complying with the requirements of the report to the board of directors.

Subd. 6. **Oversight of third-party service provider arrangements.** (a) A licensee shall exercise due diligence in selecting its third-party service provider.

(b) A licensee shall require a third-party service provider to implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information that are accessible to, or held by, the third-party service provider.

Subd. 7. **Program adjustments.** The licensee shall monitor, evaluate, and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to information systems.

Subd. 8. **Incident response plan.** (a) As part of its information security program, each licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity, or availability of nonpublic information in its possession, the licensee's information systems, or the continuing functionality of any aspect of the licensee's business or operations.

(b) The incident response plan shall address the following areas:

(1) the internal process for responding to a cybersecurity event;

(2) the goals of the incident response plan;

(3) the definition of clear roles, responsibilities, and levels of decision-making authority;

(4) external and internal communications and information sharing;

(5) identification of requirements for the remediation of any identified weaknesses in information systems and associated controls;

(6) documentation and reporting regarding cybersecurity events and related incident response activities; and

(7) the evaluation and revision, as necessary, of the incident response plan following a cybersecurity event.

Subd. 9. **Annual certification to commissioner.** (a) Subject to paragraph (b), by April 15 of each year, an insurer domiciled in this state shall certify in writing to the commissioner that the insurer is in compliance with the requirements set forth in this section. Each insurer shall maintain all records, schedules, and data supporting this certificate for a period of five years and shall permit examination by the commissioner. To the extent an insurer has identified areas, systems, or processes that require material improvement, updating, or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address such areas, systems, or processes. Such documentation must be available for inspection by the commissioner.

(b) The commissioner must post on the department's website, no later than 60 days prior to the certification required by paragraph (a), the form and manner of submission required and any instructions necessary to prepare the certification.

History: *1Sp2021 c 4 art 3 s 6*

60A.9852 INVESTIGATION OF A CYBERSECURITY EVENT.

Subdivision 1. **Prompt investigation.** If the licensee learns that a cybersecurity event has or may have occurred, the licensee, or an outside vendor or service provider designated to act on behalf of the licensee, shall conduct a prompt investigation.

Subd. 2. **Investigation contents.** During the investigation, the licensee, or an outside vendor or service provider designated to act on behalf of the licensee, shall, at a minimum and to the extent possible:

(1) determine whether a cybersecurity event has occurred;

(2) assess the nature and scope of the cybersecurity event, if any;

(3) identify whether any nonpublic information was involved in the cybersecurity event and, if so, what nonpublic information was involved; and

(4) perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release, or use of nonpublic information in the licensee's possession, custody, or control.

Subd. 3. **Third-party systems.** If the licensee learns that a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, the licensee will complete the steps listed in subdivision 2 or confirm and document that the third-party service provider has completed those steps.

Subd. 4. **Records.** The licensee shall maintain records concerning all cybersecurity events for a period of at least five years from the date of the cybersecurity event and shall produce those records upon demand of the commissioner.

History: *1Sp2021 c 4 art 3 s 7*

60A.9853 NOTIFICATION OF A CYBERSECURITY EVENT.

Subdivision 1. **Notification to the commissioner.** Each licensee shall notify the commissioner of commerce or commissioner of health, whichever commissioner otherwise regulates the licensee, without unreasonable delay but in no event later than five business days from a determination that a cybersecurity event has occurred when either of the following criteria has been met:

(1) this state is the licensee's state of domicile, in the case of an insurer, or this state is the licensee's home state, in the case of a producer, as those terms are defined in chapter 60K and the cybersecurity event has a reasonable likelihood of materially harming:

(i) any consumer residing in this state; or

(ii) any part of the normal operations of the licensee; or

(2) the licensee reasonably believes that the nonpublic information involved is of 250 or more consumers residing in this state and that is either of the following:

(i) a cybersecurity event impacting the licensee of which notice is required to be provided to any government body, self-regulatory agency, or any other supervisory body pursuant to any state or federal law; or

(ii) a cybersecurity event that has a reasonable likelihood of materially harming:

(A) any consumer residing in this state; or

(B) any part of the normal operations of the licensee.

Subd. 2. **Information; notification.** A licensee making the notification required under subdivision 1 shall provide the information in electronic form as directed by the commissioner. The licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the commissioner concerning material changes to previously provided information relating to the cybersecurity event. The licensee shall provide as much of the following information as possible:

(1) date of the cybersecurity event;

(2) description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of third-party service providers, if any;

(3) how the cybersecurity event was discovered;

(4) whether any lost, stolen, or breached information has been recovered and, if so, how this was done;

(5) the identity of the source of the cybersecurity event;

(6) whether the licensee has filed a police report or has notified any regulatory, government, or law enforcement agencies and, if so, when such notification was provided;

(7) description of the specific types of information acquired without authorization. Specific types of information means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;

(8) the period during which the information system was compromised by the cybersecurity event;

(9) the number of total consumers in this state affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the commissioner and update this estimate with each subsequent report to the commissioner pursuant to this section;

(10) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

(11) description of efforts being undertaken to remediate the situation which permitted the cybersecurity event to occur;

(12) a copy of the licensee's privacy policy and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the cybersecurity event; and

(13) name of a contact person who is familiar with the cybersecurity event and authorized to act for the licensee.

Subd. 3. **Notification to consumers.** (a) If a licensee is required to submit a report to the commissioner under subdivision 1, the licensee shall notify any consumer residing in Minnesota if, as a result of the cybersecurity event reported to the commissioner, the consumer's nonpublic information was or is reasonably believed to have been acquired by an unauthorized person, and there is a reasonable likelihood of material harm to the consumer as a result of the cybersecurity event. Consumer notification is not required for a cybersecurity event resulting from the good faith acquisition of nonpublic information by an employee or agent of the licensee for the purposes of the licensee's business, provided the nonpublic information is not used for a purpose other than the licensee's business or subject to further unauthorized disclosure. The notification must be made in the most expedient time possible and without unreasonable delay, consistent

with the legitimate needs of law enforcement or with any measures necessary to determine the scope of the breach, identify the individuals affected, and restore the reasonable integrity of the data system. The notification may be delayed to a date certain if the commissioner determines that providing the notice impedes a criminal investigation. The licensee shall provide a copy of the notice to the commissioner.

(b) For purposes of this subdivision, notice required under paragraph (a) must be provided by one of the following methods:

(1) written notice to the consumer's most recent address in the licensee's records;

(2) electronic notice, if the licensee's primary method of communication with the consumer is by electronic means or if the notice provided is consistent with the provisions regarding electronic records and signatures in United States Code, title 15, section 7001; or

(3) if the cost of providing notice exceeds $250,000, the affected class of consumers to be notified exceeds 500,000, or the licensee does not have sufficient contact information for the subject consumers, notice as follows:

(i) email notice when the licensee has an email address for the subject consumers;

(ii) conspicuous posting of the notice on the website page of the licensee; and

(iii) notification to major statewide media.

(c) Notwithstanding paragraph (b), a licensee that maintains its own notification procedure as part of its information security program that is consistent with the timing requirements of this subdivision is deemed to comply with the notification requirements if the licensee notifies subject consumers in accordance with its program.

(d) A waiver of the requirements under this subdivision is contrary to public policy, and is void and unenforceable.

Subd. 4. **Notice regarding cybersecurity events of third-party service providers.** (a) In the case of a cybersecurity event in a system maintained by a third-party service provider, of which the licensee has become aware, the licensee shall treat such event as it would under subdivision 1 unless the third-party service provider provides the notice required under subdivision 1.

(b) The computation of a licensee's deadlines shall begin on the day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.

(c) Nothing in sections 60A.985 to 60A.9858 shall prevent or abrogate an agreement between a licensee and another licensee, a third-party service provider, or any other party to fulfill any of the investigation requirements imposed under section 60A.9854 or notice requirements imposed under this section.

Subd. 5. **Notice regarding cybersecurity events of reinsurers to insurers.** (a) In the case of a cybersecurity event involving nonpublic information that is used by the licensee that is acting as an assuming insurer or in the possession, custody, or control of a licensee that is acting as an assuming insurer and that does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within three business days of making the determination that a cybersecurity event has occurred.

(b) The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under subdivision 3 and any other notification requirements relating to a cybersecurity event imposed under this section.

(c) In the case of a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a third-party service provider of a licensee that is an assuming insurer, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within three business days of receiving notice from its third-party service provider that a cybersecurity event has occurred.

(d) The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under subdivision 3 and any other notification requirements relating to a cybersecurity event imposed under this section.

(e) Any licensee acting as an assuming insurer shall have no other notice obligations relating to a cybersecurity event or other data breach under this section.

Subd. 6. **Notice regarding cybersecurity events of insurers to producers of record.** (a) In the case of a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a licensee that is an insurer or its third-party service provider and for which a consumer accessed the insurer's services through an independent insurance producer, the insurer shall notify the producers of record of all affected consumers no later than the time at which notice is provided to the affected consumers.

(b) The insurer is excused from this obligation for those instances in which it does not have the current producer of record information for any individual consumer or in those instances in which the producer of record is no longer appointed to sell, solicit, or negotiate on behalf of the insurer.

History: *1Sp2021 c 4 art 3 s 8*

60A.9854 POWER OF COMMISSIONER.

(a) The commissioner of commerce or commissioner of health, whichever commissioner otherwise regulates the licensee, shall have power to examine and investigate into the affairs of any licensee to determine whether the licensee has been or is engaged in any conduct in violation of sections 60A.985 to 60A.9857. This power is in addition to the powers which the commissioner has under section 60A.031. Any such investigation or examination shall be conducted pursuant to section 60A.031.

(b) Whenever the commissioner of commerce or commissioner of health has reason to believe that a licensee has been or is engaged in conduct in this state which violates sections 60A.985 to 60A.9857, the commissioner of commerce or commissioner of health may take action that is necessary or appropriate to enforce those sections.

History: *1Sp2021 c 4 art 3 s 9*

60A.9855 CONFIDENTIALITY.

Subdivision 1. **Licensee information.** Any documents, materials, or other information in the control or possession of the department that are furnished by a licensee or an employee or agent thereof acting on behalf of a licensee pursuant to section 60A.9851, subdivision 9; section 60A.9853, subdivision 2, clauses (2), (3), (4), (5), (8), (10), and (11); or that are obtained by the commissioner in an investigation or examination pursuant to section 60A.9854 shall be classified as confidential, protected nonpublic, or both; shall not be subject to subpoena; and shall not be subject to discovery or admissible in evidence in any private civil

action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

Subd. 2. **Certain testimony prohibited.** Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision 1.

Subd. 3. **Information sharing.** In order to assist in the performance of the commissioner's duties under sections 60A.985 to 60A.9858, the commissioner:

(1) may share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subdivision 1, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information;

(2) may receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information;

(3) may share documents, materials, or other information subject to subdivision 1, with a third-party consultant or vendor provided the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information; and

(4) may enter into agreements governing sharing and use of information consistent with this subdivision.

Subd. 4. **No waiver of privilege or confidentiality.** No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subdivision 3. Any document, material, or information disclosed to the commissioner under this section about a cybersecurity event must be retained and preserved by the licensee for five years.

Subd. 5. **Certain actions public.** Nothing in sections 60A.985 to 60A.9857 shall prohibit the commissioner from releasing final, adjudicated actions that are open to public inspection pursuant to chapter 13 to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

Subd. 6. **Classification, protection, and use of information by others.** Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant pursuant to sections 60A.985 to 60A.9857 are classified as confidential, protected nonpublic, and privileged; are not subject to subpoena; and are not subject to discovery or admissible in evidence in a private civil action.

History: *1Sp2021 c 4 art 3 s 10*

60A.9856 EXCEPTIONS.

Subdivision 1. **Generally.** The following exceptions shall apply to sections 60A.985 to 60A.9857:

(1) a licensee with fewer than 25 employees is exempt from sections 60A.9851 and 60A.9852;

(2) a licensee subject to and in compliance with the Health Insurance Portability and Accountability Act, Public Law 104-191, 110 Stat. 1936 (HIPAA), is considered to comply with sections 60A.9851, 60A.9852, and 60A.9853, subdivisions 3 to 5, provided the licensee submits a written statement certifying its compliance with HIPAA;

(3) a licensee affiliated with a depository institution that maintains an information security program in compliance with the interagency guidelines establishing standards for safeguarding customer information as set forth pursuant to United States Code, title 15, sections 6801 and 6805, shall be considered to meet the requirements of section 60A.9851 provided that the licensee produce, upon request, documentation satisfactory to the commission that independently validates the affiliated depository institution's adoption of an information security program that satisfies the interagency guidelines;

(4) an employee, agent, representative, or designee of a licensee, who is also a licensee, is exempt from sections 60A.9851 and 60A.9852 and need not develop its own information security program to the extent that the employee, agent, representative, or designee is covered by the information security program of the other licensee; and

(5) an employee, agent, representative, or designee of a producer licensee, as defined under section 60K.31, subdivision 6, who is also a licensee, is exempt from sections 60A.985 to 60A.9857.

Subd. 2. **Exemption lapse; compliance.** In the event that a licensee ceases to qualify for an exception, such licensee shall have 180 days to comply with sections 60A.985 to 60A.9858.

History: *1Sp2021 c 4 art 3 s 11*

60A.9857 PENALTIES.

In the case of a violation of sections 60A.985 to 60A.9856, a licensee may be penalized in accordance with section 60A.052.

History: *1Sp2021 c 4 art 3 s 12*

60A.9858 EXCLUSIVITY.

Notwithstanding any other provision of law, sections 60A.985 to 60A.9857 establish the exclusive state standards applicable to licensees for data security, the investigation of a cybersecurity event, and notification of a cybersecurity event.

History: *1Sp2021 c 4 art 3 s 13*

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

60A.99 INTERSTATE INSURANCE PRODUCT REGULATION COMPACT.

Subdivision 1. **Enactment and form.** The Interstate Insurance Product Regulation Compact is enacted into law and entered into with all other states legally joining in it in substantially the following form:

Article I. Purposes

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

Article II. Definitions

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Noncompacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard, or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district, or territory of the United States of America.

14. "Third Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

Article III. Establishment of the Commission and Venue

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

Article IV. Powers of the Commission

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater

protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rulemaking authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Noncompacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

Article V. Organization of the Commission

1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consist of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than 14 members shall be established as follows:

i. One member from each of the six Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four members from those Compacting States with at least two percent of the market based on the premium volume described above, other than the six Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four members from those Compacting States with less than two percent of the market, based on the premium volume described above, with one selected from each of the four zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense, and Indemnification

a. The Members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided, that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI. Meetings and Acts of the Commission

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meeting shall be held as set forth in the Bylaws.

Article VII. Rules and Operating Procedures: Rulemaking Functions of the Commission and Opting Out of Uniform Standards

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective 90 days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure, or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least 15 days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to 90 days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge

which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than 30 days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

Article VIII. Commission Records and Enforcement

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any noncomplying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

Article IX. Dispute Resolution

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Noncompacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

Article X. Product Filing and Approval

1. Insurers and Third Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

Article XI. Review of Commission Decisions Regarding Filings

1. Not later than 30 days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

Article XII. Finance

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting states.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

Article XIII. Compacting States, Effective Date and Amendment

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after 26 States are Compacting States or, alternatively, by States representing greater than 40 percent of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

Article XIV. Withdrawal, Default and Termination

1. Withdrawal

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the

Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

Article XV. Severability and Construction

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

Article XVI. Binding Effect of Compact and Other Laws

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard, or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers, or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Subd. 2. **Commission representative.** The commissioner of commerce is the representative of this state to the commission.

History: *2006 c 255 s 3*

60A.991 INTERSTATE INSURANCE PRODUCT REGULATION COMPACT OPT OUT ADMINISTRATION.

Subdivision 1. **Access to courts.** The commissioner must opt out by regulation of any uniform standard that permits a product to deny a consumer's access to the courts to resolve a dispute related to the product. In addition to opting out, the commissioner must petition the commission for a stay of the effective date of the standard.

Subd. 2. **Deference by courts.** A decision by the commissioner to opt out by regulation shall be given deference by the courts.

History: *2006 c 255 s 4*