

House Research Act Summary

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Analyst: Thomas R. Pender, 651-296-1885

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Overview

This is the department of commerce's 1999 omnibus insurance act. The act makes many technical, clarifying, and substantive changes in state laws regulating all types of insurance. Some groups of sections can be identified as distinct:

Sections 3, 4, 6, 8 to 12, 18 to 28, and 36 involve solvency regulation and liquidation of insolvent insurers. The most substantive sections are probably 4, 9, 21, 23 to 28, and 36.

Sections 7 and 13 to 15 involve demutualized former mutual insurance companies and mergers of insurance companies, including mutual holding companies. Sections 7 and 13 are substantive.

Sections 29 to 33 involve insurance agents, primarily continuing education.

Sections 37, 38, 40, 41, 43 to 50, 52 to 58, and 87 involve health insurance. Sections 37, 56, and 58 are the most substantive.

Sections 39, 59, 60, and 70 involve long-term care insurance. Sections 60 and 70 appear to be the most substantive.

Sections 66 to 69 involve automobile insurance. Section 68 is substantive.

Sections 61 to 65 involve fire insurance, including homeowner's insurance. Sections 62 and 63 are the most substantive.

Sections 72 to 86 involve regulation of worker's compensation self-insurance, especially self-insurance groups.

The remaining sections do not fit in any of the above groupings. The mostmost substantive of them is probably section 42, which involves credit disability insurance.

- 1 **Association or associations.** Current law prohibits associations from marketing insurance to new members within the first 30 days of membership. The commissioner may waive this prohibition if three conditions are met. This section adds a fourth condition, and permits a wavier if three of the four conditions are met. The new condition is that the association has been in existence for ten years.
- 2 **Filed.** Defines "filed with the commissioner" as meaning that documents have been received by the department (as opposed to having been sent to the commissioner or having been received by the commissioner personally).
- 3 **Suspension or revocation of authority or censure.** Permits the commissioner to require an insurer to cancel some or all of its existing insurance contracts.
- 4 **Withdrawal of insurer from state.** Prohibits insurers from withdrawing from this state until their obligations have been assumed by another insurer.
- 5 **Statutory lines.** Permits health and life insurers to write insurance to cover sickness, injury, or death of a person for whom the insured has assumed responsibility. This provides authority for sale of stop loss insurance to self-funded health plans or to health care providers that have assumed risk.
- 6 **Other lines.** This existing statute permits the commissioner to allow an insurer to sell lines of insurance not listed among those specifically permitted by statute; the commissioner may condition this upon the insurer meeting capital or surplus requirements specified by the commissioner. This section would amend the existing statute by permitting the commissioner to condition this permission on other solvency or policy form requirements, in addition to capital or surplus.
- 7 **Post conversion acquisition.** This section involves former mutual insurance companies that have "demutualized." This means that the mutual company reorganized by converting to a stock company and giving its members stock in the demutualized stock company in exchange for their membership interests in the former mutual company. This section would prohibit anyone (other than the demutualized company itself) from attempting to buy more than ten percent of the demutualized company's stock in the first five years after demutualization, without the prior approval of the commissioner of commerce.
- 8 **Single assuming insurer; trust fund requirements.** Clarifies the required trusted surplus for reinsurers. Permits the commissioner to require an additional amount.
- 9 **Reinsurance agreement requirements.** Provides that an insurer will not be given credit against its solvency requirements for reinsurance it has purchased unless the reinsurance contract provides that the liability of the reinsurer will not be reduced due to the insolvency of the insurer who buys the reinsurance.
- 10 **Domestic companies.** Eliminates obsolete language.
- 11 **Report.** Eliminates requirement that "alien" (non-U.S.) insurers file their ratio of assets to liability with the commissioner annually.
- 12 **Annual statements required.** Technical change to use the new definition of "filed" created earlier in this act. Also provides for electronic filing of annual and quarterly financial statements.
- 13 **Procedure to be followed.** Paragraphs (1) and (2) make technical changes in the procedure to be followed by insurance companies that want to merge. Paragraph (3) is new language specifying that insurance companies that start the procedures set forth in paragraphs (1) and (2)

may abandon the merger in compliance with what the companies agreed to in their plan of merger. Paragraph (4) applies only to mergers of two mutual insurance holding companies and specifies provisions protecting the members and their rights.

- 14 Consummation of merger.** Makes technical changes to conform to paragraphs (1) and (2) of the preceding section. Provides that the merger may be effective at a date specified in the plan of merger, rather than when the final merger documents are filed with the commissioner.
- 15 Effect of merger or consolidation.** Makes technical changes to conform to paragraphs (1) and (2) of section 12.
- 16 Requirements.** Provides that an out of state insurer may write in this state a type of insurance that the insurer is not permitted to write in its home state, if the home state's laws do not permit anyone to write that type of insurance.
- 17 Rate filing for crop hail insurance.** Changes annual deadline for filing premium rates for crop hail insurance from March 1 to February 1.
- 18 Fixing of rights.** This section is closely related to the following section. Provides that the collection of premiums authorized for a receiver under the next section is an exception to the general rule that claims of and claims against the insolvent insurer are fixed as of the date that a petition for liquidation is filed.
- 19 Powers of liquidator.** Provides specific authority for a liquidator of an insolvent insurer to collect unpaid earned premiums, including retrospective premium. Provides that premium is to be deemed earned on a pro rata basis over the term of the coverage, except for surety bonds for which a term cannot be determined.
- 20 Notice required.** Eliminates obsolete references to repealed statutes.
- 21 Reinsurer's liability.**
Subd. 1. Generally. Provides that the amount a liquidator of an insolvent insurance company can recover from a reinsurer is not reduced by reason of the insolvency, regardless of any provision to the contrary in the reinsurance or other agreement, except as permitted under subdivision 2. This subdivision is similar to a current statute, which this act repeals.
Subd. 2. Payments. Requires that a reinsurer pay the liquidator directly; payments to the insured or others do not satisfy the reinsurer's obligation, except where a contract provides for another payee under the laws of the ceding insurer's domiciliary state. Permits the receiver to recover attorney fees the receiver incurs in opposing an unsuccessful claim by a third party who asserts a right to be paid directly by the reinsurer.
- 22 Claims under terminated policies.** Eliminates an obsolete reference to a repealed statute.
- 23 Loss claims, including claims not covered by a guaranty association.** Eliminates the current preferential treatment of policyholder claims that were reinsured by the insolvent insurer.
- 24 Unearned premiums.** This section reenacts a similar subdivision repealed in this act in order to change its position. The result is to move refunds of unearned premiums owed to policyholders, so that their priority in the order of payment of claims against insolvent insurers remains immediately behind policyholder loss claims. This section is related to sections 25 to 27, and its effect is explained in the summary for section 26.
- 25 Federal government.** Moves federal claims (usually for unpaid taxes) up in the priority order for payment in liquidation of an insolvent insurer. This section is related to the following section, and its effect is explained in the summary for the following section.
- 26 Wages.** This section re-enacts a similar subdivision repealed in this act in order to change its position. It involves a special priority granted in insurance company insolvencies to unpaid

wages of insurance company employees, up to \$1,000 per employee. The effect of this section and the preceding two sections is to move unpaid wages down below policyholder claims for losses and refunds of unearned premiums in priority for payment of claims in an insolvency, but only when the federal government has a claim. A court decision requires that federal government claims be ahead of wages, but permits federal claims to be below policyholder claims. The effect of this section and the preceding two sections is to make sure policyholder claims are always ahead of federal government claims.

- 27 **Residual classification.** Makes a conforming change consistent with the preceding three sections that provide federal government claims the required priority.
- 28 **Dividends and other distributions.** Permits insurers to make distributions to shareholders out of earned surplus, without the currently required subtraction of 25 percent of unrealized capital gains. Provides that earned surplus is determined as of the end of the most recent quarter for which the insurer has filed a financial statement. Clarifies that whether a dividend is extraordinary is based upon surplus as of the most recent December 31.
- 29 **Requirement.** Clarifies that licensing as an insurance agent is required, apparently with a special limited license, to sell travel baggage, bail bonds, title insurance, and farm property and liability. Provides that a license to sell life and health insurance may either include authority to sell variable annuity contracts, or not.
- 30 **Resident agent.** Requires that classroom instruction of a prospective insurance agent include three hours on state insurance laws. Provides that the insurance licensing exam result is good for three years.
- 31 **Nonresident agent.** Provides that nonresident agents are held to the same knowledge of Minnesota insurance law as resident agents, based upon the new three-hour licensing instruction requirement added in the preceding section and the new two-hour continuing education requirement added in section 33.
- 32 **Criteria for course approval.** Eliminates the current prohibition on home study courses for insurance agent continuing education. The effective date is July 1, 2000.
- 33 **Minimum education requirement.** Provides that the continuing education requirement applies during the initial 24-month licensing period and not only during subsequent ones. Requires that two hours of the 30 hours required for continuing education cover Minnesota insurance law. Eliminates the current requirement that at least half of the continuing education hours be obtained during the first 12 months of the 24-month licensing period.
- 34 **Issuance.** Permits life insurance companies to enter into "funding agreements" with financial institutions. These are typically short-term cash management investments for the financial institutions.
- 35 **Notice form; agent sales.** Corrects an error in 1996 legislation involving life insurance replacement. The change is in clause (4) of the notice. Current law requires giving consumers a notice that is incorrect.
- 36 **Limitation of coverage.** Adds a new item to the list of situations in which the life and health insurance guaranty association does not provide coverage for policyholders of insolvent insurance companies. The new exclusion is for a product known as a "synthetic GIC." This is a type of guaranteed investment contract (GIC) that has developed in the past several years. This new exclusion also has the effect of removing these contracts from the assessment base for funding guaranty association payments to policyholders in general.
- 37 **Optional provisions.** Amends current law regarding refunds of unearned premiums if health insurance is canceled by either party. Provides that refunds must be made by insurers on a pro rata basis if the unearned premium is for more than one month. This section eliminates an

inconsistency with section 72A.20, subdivision 17.

- 38 Supplemental filings.** Changes a requirement that insurers selling fixed indemnity products (cancer insurance, hospital daily indemnity, etc.) supply loss ratio data annually. This section would require that it be filed only upon the commissioner's request.
- 39 Disclosures.** Eliminates an outdated disclosure requirement, which has been incorrect since 1989, relating to long term care insurance. Current law requires an incorrect notice.
- 40 Disclosure of methods used by health carriers to determine usual and customary fees.** Provides a definition of usual and customary fees for health care, for purposes of an existing law.
- 41 Portability and conversion of coverage.** Clarifies that preexisting condition limitations in the individual health coverage market must comply with the laws that apply in the small employer market. Clarifies the headnote to refer to paragraph (b).
- 42 Credit accident and health insurance.** Requires a disclosure notice to be provided to applicants for credit disability insurance, if the policy will not necessarily make the required monthly payments for an entire period of disability. Prescribes the form of the notice. Requires that coverage for one instance of disability be at least the full term of the loan, 24 months, or the period of disability, whichever is less.
- 43 Course cancellation; nonrenewal.** Permits health maintenance organizations (HMOs) to terminate coverage of an enrollee due to fraud or misrepresentation in connection with eligibility or another material fact by that enrollee.
- Chapter 62E technical changes.** These sections are all purely technical updates of cross-
504450 references to statutes contained in chapter 62E.
- 51 General assessment.** Technical change in assessment provisions governing the joint underwriting association, to conform to a change in forms used by the National Association of Insurance Commissioners.
- 52 Qualifying coverage.** Clarifies the definition of prior health coverage that qualifies for receiving credit against any preexisting condition limitation a person might face when changing coverage. The effect is to make it clearer that individual coverage and large group coverage qualify.
- 53 Cancellations and failures to renew.** Permits termination of an individual's coverage under an employer group health policy if that individual commits fraud or misrepresentation in connection with eligibility or another material fact.
- 54 Plan variations.** Updates the list of statutory chapters that apply to health plans issued in the small employer market. The chapter being added to the list itself provides that it applies to the small employer market, so this section of the bill is technical.
- 55 Compensation.** Permits the Health Coverage Reinsurance Association to pay its public board members up to \$55 per day spent on association business, in addition to reimbursement of their expenses. The association does not receive state money, and these payments will come from the association's own members, all of whom are insurers. These public board members are appointed by the commissioner of commerce to represent the public.
- 56 Establishment.** Postpones the date by which health plan companies are required to have an internal complaint resolution process. The date is postponed from July 1, 1999, to July 1, 2001.
- 57 Guaranteed renewability; large employer group health coverage.** Permits nonrenewal of an individual's coverage under large employer health coverage for fraud or misrepresentation by that individual.
- 58 Expedited fact finding and dispute resolution process.** Postpones the date by which the

departments of commerce and health are required to establish an external appeals process for health coverage disputes. The date is postponed from July 1, 1999, to July 1, 2001.

- 59 **Loss of functional capacity.** Clarifies a definition used in long-term care policies, first permitted under 1997 legislation, that qualify for a new federal income tax deduction available to those who itemize medical care expenses.
- 60 **Prohibited exclusion.** Limits the preexisting condition exclusion to the first six months of coverage for qualified long-term care insurance.
- 61 **Designation and scope.** Changes a cross-reference in a statute regulating the content of the standard fire insurance policy.
- 62 **Policy provisions.** Eliminates a requirement of 30 days' notice of cancellation of homeowner's insurance and other fire insurance. Does not substitute a new notice period, because that is specified in the new statute enacted in the following section.
- 63 **Time requirements.** Specifies all notice requirements that apply to cancellation or nonrenewal of homeowner's insurance and other fire insurance. Permits 20 days' notice for cancellation for nonpayment of premium and for nonrenewal of a policy that is less than 60 days old.
- 64 **Homeowner's insurance.** Clarifies that the term "homeowner's insurance" includes coverage for manufactured homes, dwelling owners, condominium owners, and tenants. This replaces section 65A.29, subdivision 12, which this act repeals. That current provision refers only to "mobile homes."
- 65 **Form requirements.** If an application for homeowner's insurance is turned down or if the insurer cancels or refuses to renew an existing policy, requires that the written notice inform the person of the FAIR plan (high risk pool), the right to complain to the commissioner, and the right to a refund of unearned premium.
- 66 **Qualified applicant.** Makes a technical change to update a term used in the definition of persons eligible for the state auto plan, which is a high-risk pool for auto insurance.
- 67 **Inclusions.** Clarifies the required minimum policy limit for auto insurance no-fault benefits.
- 68 **Motorcycle insurance.** Requires that applicants for motorcycle insurance be told in writing that it does not provide personal injury protection (PIP) and that the applicant's automobile PIP coverage will not cover motorcycle injuries.
- 69 **Collision damage waiver.** Eliminates a reference to an inappropriate statute.
- 70 **HIV tests; crime victims and emergency medical service personnel.** The existing law amended here prevents insurers from using, for health insurance underwriting purposes, HIV tests performed on crime victims and emergency medical personnel. This section extends this prohibition to underwriting for long-term care insurance.
- 71 **Fees.** Eliminates a fee payable to the commerce department for public adjuster examinations. The applicants now pay these fees instead to a private vendor that gives the examinations. Provides that public adjustor license fees should be paid to the department of commerce, rather than to the state treasurer, in accordance with current practice.
- 72 **Common claims fund.** Technical change to recognize that workers' compensation self-insurance groups are not "mutual."
- 73 **Diminutive applicants.** Defines this term to mean applicants to join existing workers' compensation self-insurance groups where the additional equity and premium would be less than five percent of the group's total.
- 74 **Membership.** Corrects an apparent error in 1995 legislation, so as to permit the commissioner of commerce to appoint two members (rather than just their alternates) to the workers' compensation self-insurance advisory committee. This group advises the commissioner on

applications by employers to self-insure for workers' compensation.

- 75 Audit of self-insurance application.** Provides that financial reviews of applications to self-insure for workers' compensation will be provided by the self-insurers' security fund only when requested by an advisory committee.
- 76 Recommendations to commissioner regarding revocation.** Provides that for workers' compensation self-insurers who have been in existence for more than five years, the solvency requirement in this section supersedes a requirement in another section and rule that might otherwise conflict.
- 77 Applications for group self-insurance.** Specifies the procedure for new members to join an existing workers' compensation self-insurance group. Requires ten days notice to the commissioner before new "diminutive applicants" join, unless the cumulative total of premium added by new diminutive members exceeds 50 percent in a fiscal year, in which case 45 days notice is required. Requires evidence that prospective new member have paid premiums into a common claims fund.
- 78 Financial standards.** Clarifies that requirements apply to workers' compensation self-insurer groups after approval as well as to groups applying for approval to self-insure.
- 79 Filing reports.** Eliminates need for workers' compensation self-insurers to file claims data with the commissioner. Beginning in 1997, this information has been reported to the Minnesota Workers Compensation Insurers Association under section 79A.32. Changes the deadlines for filing financial statements from four months to seven months after end of the group's fiscal year.
- 80 Annual audits and refunds.** Permits workers' compensation self-insured groups to refund to their members surplus funds as described in this section.
- 81 Annual requirements.** Specifies that the financial requirements for individual and group workers' compensation self-insurers must be met on an annual basis and not just at the time of initial application.
- 82 Private employers who have ceased to be self-insured.** Provides that, if a former workers' compensation self-insurer buys a workers' compensation insurance policy that covers the period of time during which the employer was self-insured, the self-insurers' security fund is discharged of obligations to pay claims and the employer is discharged of obligations to pay assessments to the fund for that period. Also provides similar provisions for purchase of a policy covering a portion of the period of self-insurance.
- 83 Private employers who are self-insured.** Permits employers that are still self-insured for worker's compensation to buy insurance policies covering past periods, with the same effects as in the preceding section.
- 84 Required documents.** Provides that the documents required by this section are required for initial applications for approval as commercial workers' compensation self-insured groups and not for renewal applications. Permits an optional type of financial filing.
- 85 Required reports to commissioner.** Changes the annual deadline for certain filings by workers' compensation self-insurance groups. Permits an optional type of financial filing.
- 86 Required reports from members to groups.** Changes the annual deadline for members of workers' compensation self-insurance groups to submit annual financial statements to the group. Requires smaller members of the group to submit "compiled" financial statements. ("Compiled" financial statements are subjected to a lower standard of review by certified public accountants than are "reviewed" or "audited" financial statements.)
- 87 Participation required for reimbursement under other state health care programs.** Technical correction of a cross-reference to chapter 62E.

- 88** **Repealer.** Eliminates data processing systems as an admitted asset in a section that specifies admitted assets for insurers other than life insurers. Repeals definition of homeowner's insurance, section on reinsurer's liability, and requirement of return of excess self-insured workers' compensation security, all of which are replaced in this act. Repeals the liquidation priority for wages and refunds of unearned premiums in order to reenact them in this act with a changed priority.
- 89** **Effective dates.** Provides various effective dates. Makes sections 13 to 15 effective immediately, but permits mergers under the current versions of sections 13 to 15 for agreements entered into prior to January 1, 2000.