SENATE BILL NO. 151

INTRODUCED BY MAHLUM

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT; CLARIFYING THAT THE ACT APPLIES TO INSOLVENT INSURERS AS WELL AS IMPAIRED INSURERS; ESTABLISHING PROCEDURES FOR AN ASSOCIATION TO ELECT TO CONTINUE REINSURANCE; PROVIDING FOR THE DISTRIBUTION OF DEPOSITS PAID TO AN ASSOCIATION; CLARIFYING THE SCOPE OF COVERAGE OF THE ACT; REVISING DEFINITIONS; DEFINING "BENEFIT PLAN", "INSOLVENT INSURER", "MOODY'S CORPORATE BOND YIELD AVERAGE", "PLAN SPONSOR", "PRINCIPAL PLACE OF BUSINESS", "RECEIVERSHIP COURT", "STRUCTURED SETTLEMENT ANNUITY", AND "SUPPLEMENTAL CONTRACT"; REVISING REQUIREMENTS FOR ACCOUNTS MAINTAINED BY AN ASSOCIATION; CLARIFYING THE STANDING AND GENERAL POWERS OF AN ASSOCIATION; CLARIFYING MEETING AND NEGOTIATION REQUIREMENTS; CLARIFYING THE DUTIES AND POWERS OF THE INSURANCE COMMISSIONER; REVISING AN ASSOCIATION'S POWERS PRIOR TO AND DURING THE LIQUIDATION OF A MEMBER INSURER; REVISING ASSIGNMENT AND SUBROGATION PROVISIONS; REVISING BENEFIT LIABILITY OF AN ASSOCIATION; AMENDING SECTIONS 33-10-201, 33-10-202, 33-10-203, 33-10-205, 33-10-206, 33-10-207, 33-10-210, 33-10-215, 33-10-217, 33-10-219, 33-10-220, 33-10-221, 33-10-222, 33-10-223, 33-10-224, 33-10-226, AND 33-10-227, MCA; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Association election to continue reinsurance.** (1) Within 1 year after the coverage date, which is the date that the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of a member insurer that accrued on or after the coverage date under an indemnity reinsurance agreement entered into by the member insurer as the ceding insurer. The association may not exercise an election with respect to a reinsurance agreement if the rehabilitator or liquidator of the member insurer has previously expressly disaffirmed the agreement.

(2) The election to succeed to the rights and obligations of the member insurer must be accomplished through notice to the supervisor, rehabilitator, or liquidator and to the affected reinsurers.

(3) If the association makes an election, the association:

(a) is responsible for all unpaid premiums due under the agreements for the periods before and after the coverage date and is responsible for the performance of all obligations to be performed after the coverage date in each contract covered, either in whole or in part, by the association. The association may charge contracts covered in part by the association the costs for reinsurance in excess of the obligations of the association, using reasonable allocation methods.

(b) is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part. In order to receive these amounts, the association must be obligated to pay the beneficiary of the underlying policy or contract a portion of the amount equal to the excess of the amount received by the association minus:

(i) the benefits paid by the association under the policy or contract; and

(ii) any amount properly retained by the impaired or insolvent insurer for the loss or event.

(c) shall calculate, within 30 days of the election, the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid to either the member insurer, its rehabilitator or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or the indemnity insurer shall pay the net balance due the other within 5 days of completion of the calculation. If the rehabilitator or liquidator has received any amount under this section, the rehabilitator or liquidator shall remit it to the association as soon as practicable.

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

(5) The association may transfer any rights or obligations under this section to a third-party insurer under terms agreed upon by the association and the third-party insurer.

(6) Except as otherwise expressly stated in this section, this section may not be construed to alter or modify the terms and conditions of the reinsurance agreement of an insolvent member insurer. This section is not intended to:

(a) abrogate or limit any rights of a reinsurer to claim that it is entitled to rescind a reinsurance

agreement; or

(b) give a policyowner or beneficiary an independent cause of action against an insurer that is not otherwise provided for in the reinsurance agreement.

NEW SECTION. **Section 2. Deposits paid to association.** (1) A deposit in this state that is held pursuant to law or required by the commissioner to be held for the benefit of creditors, including policyowners, and that is not turned over to the liquidator upon entry of the final order of liquidation or upon entry of the order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state pursuant to 33-2-1381 must be promptly paid to the association.

(2) The association is entitled to retain a portion of any amount paid under this section equal to the percentage determined by dividing the aggregate amount of policyowner claims related to the insolvency for which the association has provided statutory benefits by the aggregate amount of all policyowner claims in this state related to the insolvency. The association shall remit to the domiciliary receiver the amount paid to the association and not retained under this section.

Section 3. Section 33-10-201, MCA, is amended to read:

"33-10-201. Short title, purpose, scope, and construction. (1) This part may be cited as the "Montana Life and Health Insurance Guaranty Association Act".

(2) The purpose of this part is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the insurer issuing the policies or contracts.

(3) To provide this protection:

(a) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages;

(b) members of the association are subject to assessment to provide funds to carry out the purpose of this part; and

(c) the association is authorized to assist the commissioner, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

(4) This part applies to direct, nongroup life, health, and annuity policies and contracts~~,~~ and their

supplemental ~~policies or~~ contracts, to certificates under direct group policies and contracts, and to unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement ~~agreements~~ annuities, lottery ~~contracts~~ annuities issued in connection with government lotteries, and any immediate or deferred annuity contracts.

(5) This part provides coverage for policies and contracts specified in subsection ~~(6)~~ (4):

(a) to persons who are owners of or certificate holders under covered policies or contracts, other than unallocated annuity contracts and structured settlement annuities that are provided for in subsections (6) and (7), ~~in the case of unallocated annuity contracts, to the persons who are contract holders~~ if the persons:

(i) are residents; or

(ii) are not residents, but only under all of the following conditions:

(A) the insurers that issued the policies are domiciled in this state;

(B) the insurers have not held a license or certificate of authority in the state in which the persons reside;

(C) the state has an association similar to the association created under this part; and

(D) the persons are not eligible for coverage by that association; and

(b) to persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under subsection (5)(a).

(6) With respect to unallocated annuity contracts, this part provides coverage to:

(a) persons who are the owners of unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(b) persons who are owners of unallocated annuity contracts issued in connection with government lotteries if the owners are residents.

(7) (a) With respect to structured settlement annuities, this part provides coverage to a person who is:

(i) a payee under a structured settlement annuity;

(ii) a beneficiary of a payee if the payee is deceased; or

(iii) a resident payee, regardless of where the contract owner resides.

(b) This part also applies to a payee of a structured settlement annuity contract who is not a resident if:

(i) the contract owner of the structured settlement annuity is a resident, the insurer that issued the structured settlement annuity is domiciled in this state, or the state in which the contract owner resides has an

association similar to the association created by this part; and

(ii) the payee, beneficiary, or contract owner is not eligible for coverage by the association in the state in which the payee or contract owner resides.

(8) This part does not provide coverage to:

(a) a person who is a payee or a beneficiary of a contract owner who is the resident of another state if the payee or beneficiary is afforded any coverage by the association of another state; or

(b) a person described in subsection (5) if the person is afforded any coverage by the association of another state.

(9) (a) This part is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person may not be provided coverage under this part.

(b) In determining the application of this subsection (9) to situations in which a person, such as an owner, payee, beneficiary, or assignee, could be covered by the associations of more than one state, this part must be construed in conjunction with other state laws to result in coverage by only one association.

~~(6)~~(10) ~~This part covers persons specified in subsection (5)(a) for direct, nongroup life, health, annuity, and supplemental policies and contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, allocated and unallocated funding agreements, structured settlement agreements, lottery contracts, and immediate or deferred annuity contracts.~~ This part does not ~~apply to~~ provide coverage for:

(a) policies or contracts or any part of the policies or contracts not guaranteed by the member insurer or under which the risk is borne by the ~~policyholder~~ policyowner;

(b) a policy or contract or part of the policy or contract assumed by the impaired member insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

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

(i) averaged over the period of 4 years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average averaged for that same 4-year period or for the lesser period if the policy

or contract was issued less than 4 years before the association became obligated; and

(ii) on and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as is most recently available;

(d) any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees, ~~or~~ members, or others to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or ~~similar entity~~ other person under:

(i) a multiple employer welfare arrangement, as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(ii) a minimum premium group insurance plan;

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

(iv) an administrative services only contract;

(e) any portion of a policy or contract to the extent that it provides dividends, ~~or~~ experience rating credits, or voting rights or provides that any fees or allowances be paid to any person, including the ~~policy~~ policyowner or contract ~~holder~~ owner, in connection with the service to or administration of the policy or contract;

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

(g) any unallocated annuity contract issued to or in connection with an employee benefit plan that is protected under the federal pension benefit guaranty corporation regardless of whether the federal pension benefit guaranty corporation is liable to make any payments with respect to the employee benefit plan; ~~and~~

(h) any portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery~~.~~;

(i) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policyowner or contract owner, including without limitation:

(i) claims based on marketing materials;

(ii) claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable requirements for filing policy forms or for policy approval;

(iii) misrepresentations of or regarding policy benefits;

(iv) extracontractual claims; or

(v) a claim for penalties or consequential or incidental damages;

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

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

~~(7)~~(11) This part must be liberally construed to effect the purpose under subsections (2) and (3), which constitute an aid and guide to interpretation.

~~(8)~~(12) This part may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability."

Section 4. Section 33-10-202, MCA, is amended to read:

"33-10-202. Definitions. As used in this part, the following definitions apply:

(1) "Account" means either of the two accounts created under 33-10-203.

(2) "Association" means the Montana life and health insurance guaranty association created under 33-10-203.

(3) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

~~(3)~~(4) "Contractual obligation" means any obligation under covered policies.

~~(4)~~(5) "Covered policy" means any policy or contract within the scope of this part under 33-10-201(4) through ~~(6)~~ (10).

~~(5)~~(6) "Impaired insurer" means~~:~~

~~(a) an insurer that becomes insolvent and is placed under a final order of liquidation, rehabilitation, or supervision by a court of competent jurisdiction; or~~

~~(b) an insurer considered by the commissioner to be unable or potentially unable to fulfill its contractual obligations~~ a member insurer that is not an insolvent insurer and that is placed under an order of rehabilitation

or supervision by a court of competent jurisdiction.

(7) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction upon a finding of insolvency.

~~(6)~~(8) (a) "Member insurer" means an insurer that is licensed or that holds a certificate of authority to transact any kind of insurance in this state for which coverage is provided under 33-10-201 and 33-10-224 and includes any insurer whose license or certificate of authority may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The term does not include:

(i) a health service corporation;

(ii) a health maintenance organization;

(iii) a fraternal benefit society;

(iv) a mandatory state pooling plan;

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

(vi) an insurance exchange; ~~or~~

(vii) an organization that has a certificate or license limited to the issuance of charitable gift annuities; or

~~(vii)~~(viii) an entity similar to any of the entities listed in subsections ~~(6)(b)(i) through (6)(b)(vi)~~ (8)(b)(i) through (8)(b)(vii).

(9) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or its successor.

(10) "Owner", "contract owner", and "policyowner" mean the person who is identified as the legal owner under the terms of a policy or contract or who is vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and who is properly recorded as the owner on the books of the insurer.

~~(7)~~(11) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(12) "Plan sponsor" means:

(a) the employer in the case of a benefit plan established or maintained by a single employer;

(b) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(c) in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees,

or other similar group of representatives of the parties who establish or maintain the benefit plan.

~~(8)~~(13) (a) "Premiums" means ~~direct gross insurance premiums and annuity considerations written on covered policies, less return premiums and considerations on premiums and dividends paid or credited to policyholders on the direct business.~~

~~(b) The term does not include premiums and considerations on contracts between insurers and reinsurers.~~

~~(c) As used in 33-10-227, premiums are those for the calendar year preceding the determination of impairment~~ the amount or consideration received on covered policies or contracts less return premiums, considerations, and deposits, and less dividends and experience credits.

(b) The term does not include:

(i) amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided pursuant to 33-10-201(10), except that an assessable premium may not be reduced based on 33-10-201(10)(c) relating to interest limitations and 33-10-224 relating to one individual, one participant, and one contract owner;

(ii) premiums in excess of $5 million on an unallocated annuity contract not issued under a governmental retirement benefit plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code; or

(c) premiums in excess of $5 million with respect to multiple nongroup policies of life insurance owned by one owner, whether the policyowner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons.

(14) "Principal place of business" of a plan sponsor means:

(a) the state in which more than 50% of the participants in the benefit plan are employed;

(b) with respect to a plan sponsor as defined in 33-10-202(12)(c), the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan, or, in lieu of specific or clear designation of a principal place of business, the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question; or

(c) if 50% of the participants are not employed in a single state, the single state in which the individuals who establish policies for the direction, control, and coordination of the operations of the plan sponsor as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the following factors:

(i) the state in which the primary executive and administrative headquarters of the plan sponsor is located;

(ii) the state in which the principal office of the chief executive officer of the plan sponsor is located;

(iii) the state in which the board of directors or similar governing person or persons of the plan sponsor conduct its meetings;

(iv) the state in which the executive or management committee of the board of directors or similar governing person or persons of the plan sponsor conduct the majority of its meetings;

(v) the state from which the management of the overall operations of the plan sponsor is directed; and

(vi) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

(15) "Receivership court" means the court in the insolvent or impaired insurer's state that has jurisdiction over the supervision, rehabilitation, or liquidation of the insurer.

~~(9)~~(16) "Resident" means a person who resides in this state at the time that the impairment is determined and to whom contractual obligations are owed. A person may be a resident of only one state, and in the case of a person other than an individual, the person is a resident of the state where its principal place of business is located. Citizens of the United States who are either residents of foreign countries or residents of the possessions, territories, or protectorates of the United States and who do not have an association similar to the association created by this part must be considered residents of the state of domicile of the insurer that issued the policies or contracts.

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

(18) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

~~(10)~~(19) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by the insurer under the contract or certificate."

Section 5. Section 33-10-203, MCA, is amended to read:

"33-10-203. Creation of the association -- accounts -- supervision by commissioner. (1) There is

created a nonprofit legal entity to be known as the Montana life and health insurance guaranty association. All member insurers ~~shall~~ must be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under 33-10-216 and shall exercise its powers through a board of directors established under 33-10-204.

(2) For purposes of administration and assessment, the association shall maintain two accounts:

(a) the health insurance account; and

(b) the life insurance and annuity account that includes the following subaccounts:

(i) the life insurance account;

(ii) the annuity account that includes contracts owned by a governmental retirement plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code, but does not otherwise include unallocated annuities; and

(iii) the unallocated annuity account that must include unallocated annuity contracts ~~qualified~~ owned by a governmental retirement benefit plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code.

(3) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. ~~Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.~~"

Section 6. Section 33-10-205, MCA, is amended to read:

"33-10-205. General powers of association -- standing. (1) In addition to other rights provided by law, the ~~The~~ association may:

(a) enter into ~~such~~ contracts ~~as~~ that are necessary or proper to carry out the provisions and purposes of this part;

(b) sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under 33-10-228 and to settle claims or potential claims against it;

(c) borrow money to effect the purposes of this part. Any notes or other evidence of indebtedness of the association not in default ~~shall~~ must be legal investments for domestic insurers and may be carried as admitted assets.

(d) employ or retain ~~such~~ persons ~~as~~ who are necessary to handle the financial transactions of the association and to perform ~~such~~ other functions ~~as~~ that become necessary or proper under this part;

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

(f) take ~~such~~ legal action ~~as~~ that may be necessary to avoid payment of improper claims;

(g) exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but ~~in no case may~~ the association may not in any case issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer;

(h) request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this part with respect to the person. The person shall promptly comply with the request.

(i) take other necessary or appropriate action to discharge its duties and obligations under this part or to exercise its powers under this part.

(2) The association may render assistance and advice to the commissioner, upon ~~his~~ request, concerning rehabilitation, liquidation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(3) The association ~~shall have~~ has standing to appear or intervene before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part or before any court with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. ~~Such~~ The association's standing ~~shall extend~~ extends to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring, modifying, or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or before a court with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(4) The board of directors of the association may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(5) When the association has arranged or offered to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(6) Venue in a suit against the association arising under this part is in ~~Lewis and Clark County~~ THE FIRST

JUDICIAL DISTRICT. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this part."

Section 7. Section 33-10-206, MCA, is amended to read:

"33-10-206. Records of meetings and negotiations. Records ~~shall~~ must be kept of all negotiations and meetings ~~in which the association or its representatives are involved~~ of the board of directors held to discuss the activities of the association in carrying out its powers and duties under this part. Records of ~~such~~ negotiations or meetings pertaining to an impaired or insolvent insurer ~~shall~~ may be made public only upon the termination of a liquidation, rehabilitation, or supervision proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. ~~Nothing in this~~ This section ~~shall~~ does not limit the duty of the association to render a report of its activities under 33-10-209."

Section 8. Section 33-10-207, MCA, is amended to read:

"33-10-207. Immunity. There ~~shall~~ may not be ~~no~~ any liability on the part of and ~~no~~ there may not be a cause of action of any nature ~~shall arise~~ against any member insurer or its ~~insurance producers~~ agents or employees, the association or ~~its insurance producers~~ the association's agents or employees, members of the board of directors, or the commissioner or ~~his~~ the commissioner's representatives for any action taken by them in the performance of their powers and duties under this part."

Section 9. Section 33-10-210, MCA, is amended to read:

"33-10-210. Unfair trade practice -- notice to ~~policyholders~~ policyowners. (1) It is a prohibited unfair trade practice for any person to make use in any manner of the protection afforded by this part in the sale of insurance.

(2) ~~Within 180 days after October 1, 1993, the~~ The association shall prepare a summary document, complying with subsection (3) and describing the general purposes and current limitations of this part. The document must be submitted to the commissioner for approval. Sixty days after receiving approval, an insurer may not deliver a policy or contract described in 33-10-201(4) to a ~~policy~~ policyowner or contract ~~holder~~ owner unless the document is delivered to the ~~policy~~ policyowner or contract ~~holder~~ owner prior to or at the time of delivery of the policy or contract, unless subsection (4) of this section applies. The document must be available upon request by a ~~policyholder~~ policyowner. The distribution, delivery, contents, or interpretation of this document

does not mean that either the policy or the contract or the ~~holder~~ owner of the policy or contract would be covered in the event of the impairment or insolvency of a member insurer. The description document must be revised by the association as amendments to this part may require. Failure to receive this document does not give the ~~policyholder~~ policyowner, contract ~~holder~~ owner, certificate holder, or insured any greater rights than those stated in this part.

(3) The document prepared under subsection (2) must contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer must:

(a) state the name and address of the life and health insurance guaranty association and insurance department;

(b) prominently warn the ~~policy~~ policyowner or contract ~~holder~~ owner that the life and health insurance guaranty association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(c) state that the insurer and its insurance producers are prohibited by law from using the existence of the life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(d) emphasize that the ~~policy~~ policyowner or contract ~~holder~~ owner should not rely on coverage under the life and health insurance guaranty association when selecting an insurer;

(e) provide other information as directed by the commissioner.

(4) An insurer or insurance producer may not deliver a policy or contract described in 33-10-201(4) and excluded under 33-10-201~~(6)(a)~~(10) from coverage under this part unless the insurer or insurance producer, prior to or at the time of delivery, gives the ~~policy~~ policyowner or contract ~~holder~~ owner a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the life and health insurance guaranty association.

(5) The commissioner shall by rule specify the form and content of the notice required under subsection (4)."

Section 10. Section 33-10-215, MCA, is amended to read:

"33-10-215. Duties and powers of ~~the~~ commissioner. In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

(1) notify the board of directors of the existence of an impaired or insolvent insurer not later than 3 days

after a determination of impairment or insolvency is made or ~~he~~ the commissioner receives notice of impairment or insolvency;

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

(3) when an impairment or insolvency is declared and the amount of the impairment or insolvency is determined, serve a demand upon the impaired or insolvent insurer to make good the impairment or insolvency within a reasonable time. Notice to the impaired or insolvent insurer ~~shall constitute~~ constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with ~~such~~ the demand ~~shall~~ does not excuse the association from the performance of its powers and duties under this part.

(4) in any liquidation or rehabilitation proceeding involving a domestic insurer be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the commissioner ~~shall~~ must be appointed conservator.

(5) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer that fails to pay an assessment when due. The fine may not exceed 5% of the unpaid assessment per month, except that the fine may not be less than $100 per month.

(6) A final action of the board of directors may be appealed to the commissioner by a member insurer if the appeal is taken within 60 days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(7) The liquidator or rehabilitator of an impaired or insolvent insurer may notify all affected persons of the effect of this part."

Section 11. Section 33-10-217, MCA, is amended to read:

"33-10-217. Prevention of insolvencies or impairments. (1) To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner shall:

(a) (i) notify the commissioners of all the other states, the territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:

(A) the revocation of a license;

(B) the suspension of a license; or

(C) the issuance of any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of ~~policyholders~~ policyowners or creditors;

(ii) mail the notice to all commissioners within 30 days following the action taken or the date on which the action occurs;

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

(c) report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer; and

(d) furnish to the board of directors the national association of insurance commissioners' insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners. The board of directors may use the information contained in the ratios and listings in carrying out its duties and responsibilities under this section. The report and the information contained in the ratios and listings must be kept confidential by the board of directors until the time it is made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(3) The board of directors shall, upon majority vote, notify the commissioner of any information indicating any member insurer may be unable or potentially unable to fulfill its contractual obligations.

(4) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be unable or potentially unable to fulfill its contractual obligations.

(5) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or supervision of any member insurer or germane to the solvency of any company seeking to provide life or health insurance in this state. The reports and recommendations are not considered public documents.

(6) The board of directors may, upon majority vote, make recommendations to the commissioner for the

detection and prevention of insurer impairments or insolvencies.

(7) The board of directors shall, at the conclusion of any insurer impairment or insolvency in which the association carried out its duties under this part or exercised any of its powers under this part, prepare a report on the history and causes of the impairment or insolvency, based on the information available to the association, and submit the report to the commissioner. The board of directors shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of impairment or insolvency of a particular insurer and may adopt by reference any report prepared by other associations."

Section 12. Section 33-10-219, MCA, is amended to read:

"33-10-219. Impaired insurer -- association's powers prior to liquidation. If ~~an~~ a member insurer is an impaired insurer, the association may, ~~prior to an order of liquidation or rehabilitation and~~ subject to any conditions imposed by the association other than those ~~which~~ that impair the contractual obligations of the impaired insurer and that are approved by the ~~impaired insurer and the~~ commissioner:

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

(2) provide ~~such moneys~~ money, pledges, notes, guarantees, or other means ~~as~~ that are proper to effectuate this section and ~~assure~~ ensure payment of the contractual obligations of the impaired insurer pending action under ~~subsection (1); and~~ this section.

~~(3) loan money to the impaired insurer.~~"

Section 13. Section 33-10-220, MCA, is amended to read:

"33-10-220. ~~Impaired~~ Insolvent insurer -- association's powers during liquidation. (1) If an insurer is an ~~impaired~~ insolvent insurer ~~under an order of liquidation or rehabilitation~~, the association shall, subject to the approval of the commissioner:

(a) guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of the ~~impaired~~ insolvent insurer;

(b) ~~assure~~ ensure payment of the contractual obligations of the ~~impaired~~ insolvent insurer~~;~~ and

~~(c)~~ provide ~~such moneys~~ money, pledges, notes, guarantees, or other means ~~as~~ that are reasonably necessary to discharge ~~such~~ its duties; or

(c) provide benefits and coverages in accordance with the provisions of subsection (6).

(2) If the association fails to act within a reasonable period of time, the commissioner ~~shall have~~ has the

powers and duties of the association under this part with respect to ~~such~~ a domestic, foreign, or alien ~~impaired~~ insolvent insurer.

(3) In carrying out its duties under subsection (1), the association may request that there be imposed policy liens, contract liens, moratoriums on payments, or other similar means; and ~~such~~ the liens, moratoriums, or similar means may be imposed if the commissioner:

(a) finds that the amounts ~~which~~ that can be assessed under this part are less than the amounts needed to ~~assure~~ ensure full and prompt performance of the ~~impaired~~ insolvent insurer's contractual obligations or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, moratoriums, or similar means to be in the public interest; and

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

(4) Before being obligated under subsection (1), the association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans, and ~~such~~ the temporary moratoriums and liens may be imposed if they are approved by the commissioner.

(5) The association ~~shall have no liability~~ is not liable under 33-10-219 or this section for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides by statute or regulation for residents of this state protection substantially similar to that provided by this part for residents of other states.

(6) (a) If proceeding under this section, the association may, with respect to life and health insurance policies and annuities:

(i) ~~assure~~ ensure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer for claims incurred:

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

(B) with respect to individual policies or contracts, not later than the earlier of the next renewal date, if any, under the policies or contracts or 1 year, but in ~~no~~ any event not less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) make diligent efforts to provide all known insureds, annuitants, or group ~~policyholders~~ policyowners with respect to group policies, 30 days' notice of the termination of the benefits provided; and

(iii) make available substitute coverage on an individual basis in accordance with subsection (6)(b) to each known insured or annuitant, or owner if other than the insured or annuitant, of an individual policy or contract

and to any individual formerly insured under a group policy who is not eligible for replacement group coverage, if the insured or annuitant had a right under law or the terminated policy or contract to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(b) (i) In providing the substitute coverage required under subsection (6)(a)(iii), the association may offer to reissue the terminated coverage or issue an alternative policy.

(ii) Reissued or alternative policies must be offered without requiring evidence of insurability and may not provide for any waiting period or exclusion that would not have applied under the terminated policy.

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

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

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

(iii) Alternative policies issued by the association shall provide coverage of a type similar to that of the policy issued by the ~~impaired or~~ insolvent insurer, as determined by the association.

(d) If the association elects to reissue terminated coverage at a premium different from that charged under the terminated policy, the premium must be set by:

(i) the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner; or

(ii) a court of competent jurisdiction.

(e) The association's obligation with respect to coverage under any policy or contract of the ~~impaired or~~ insolvent insurer or under any reissued or alternative policy ceases on the date the coverage or policy is replaced by another similar policy by the ~~policyholder~~ policyowner, insured, or association.

(f) When proceeding under this section with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall ensure the payment or crediting of a rate of interest consistent with 33-10-201(10).

(7) In carrying out its duties under this section, the association may, subject to the approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) in lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(i) a fixed interest rate;

(ii) payment of dividends with minimum guarantees; or

(iii) a different method for calculating interest or changes in value;

(b) there is not a requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

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

(8) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this part with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with the provisions of this part.

(9) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable only for unearned premiums due to policyowner or contract owners arising after the entry of the order of liquidation.

(10) The protection provided by this part does not apply when any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the insolvent insurer that is other than this state."

Section 14. Section 33-10-221, MCA, is amended to read:

"33-10-221. Nomination of liquidator by association -- notification given by liquidator. (1) The association may recommend ~~a natural person~~ an individual to serve as a special deputy to act for the commissioner and under ~~his~~ the commissioner's supervision in the liquidation, rehabilitation, or supervision of any member insurer.

(2) The liquidator, rehabilitator, or supervisor of any impaired or insolvent insurer may notify all interested

persons of the effect of this part."

Section 15. Section 33-10-222, MCA, is amended to read:

"33-10-222. Stay of proceedings -- reopening default judgments. (1) All proceedings in which the impaired or insolvent insurer is a party in any court in this state ~~shall~~ must be stayed 60 days from the date an order of liquidation, rehabilitation, or supervision is final to permit proper legal action by the association on any matters germane to its powers or duties.

(2) As to a judgment under any decision, order, verdict, or finding based on default, the association may apply to have ~~such~~ the judgment set aside by the same court that made ~~such~~ the judgment and ~~shall~~ must be permitted to defend against ~~such~~ the suit on the merits."

Section 16. Section 33-10-223, MCA, is amended to read:

"33-10-223. Assignment by beneficiaries -- subrogation. (1) Any person receiving benefits under this part ~~shall~~ must be ~~deemed~~ considered to have assigned ~~his~~ the person's rights under the covered policy or contract, pertaining to any causes of action against the person for losses resulting from or otherwise relating to the covered policy or contract, to the association to the extent of the benefits received because of this part whether the benefits are payments of contractual obligations or continuation of coverage or provision of substitute or alternative coverage. The association may require an assignment to it of ~~such~~ the rights by any payee, ~~policy~~ policyowner or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this part upon ~~such~~ the person. The association ~~shall~~ must be subrogated to these rights against the assets of any impaired insurer.

(2) The subrogation rights of the association under this section ~~shall~~ have the same priority against the assets of the impaired insurer as that possessed by the person entitled to receive benefits under this part.

(3) In addition to the rights detailed in this section, the association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this part, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity, except for any person responsible solely by reason of serving as an assignee with respect to a qualified assignment under section 130 of the Internal Revenue Code.

(4) If subsections (1) through (3) are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policy or a portion of the policy covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers any amount to which the association has rights as described in this section, the person shall pay to the association the portion of the recovery attributable to the policy or a portion of the policy covered by the association."

Section 17. Section 33-10-224, MCA, is amended to read:

"33-10-224. Extent of liability. (1) The benefits for which the association may become liable may not exceed the lesser of:

~~(1)~~(a) the contractual obligations of the impaired or insolvent insurer for which the insurer becomes or would have become liable if it were not an impaired or insolvent insurer; or

~~(2) (a)~~(b) (i) except as provided in subsection (2), with respect to any one life, regardless of the number of policies or contracts:

~~(i)~~(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

~~(ii)~~(B) ~~$100,000~~ in health insurance benefits~~,~~:

(I) $500,000 for basic hospital, medical, and surgical insurance or major medical insurance as defined in the covered policy or contract;

(II) $300,000 for disability insurance as defined in the covered policy or contract;

(III) $100,000, including any net cash surrender and net cash withdrawal values, for coverages not included in (1)(b)(i)(B)(I) and (1)(b)(i)(B)(II);

~~(iii)~~(C) $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

~~(b)~~(ii) with respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code and covered by an unallocated annuity contract or with respect to the beneficiaries of each individual, if deceased, in the aggregate, $100,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values~~.~~; ~~However, the association is not liable to expend more than $300,000 in the aggregate with respect to any one individual under subsection (2)(a) and this~~

~~subsection.~~

~~(c)~~(iii) with respect to any one contract ~~holder~~ owner covered by any unallocated annuity contract not included in subsection ~~(2)(b)~~ (1)(b)(ii), $5 million in benefits, irrespective of the number of contracts held by that contract ~~holder.~~ owner;

(iv) with respect to each payee of a structured settlement annuity or beneficiary of the payee if the payee is deceased, $100,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(v) with respect to either one contract owner provided coverage under 33-10-201(6) or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subsection (1)(b)(ii), $5 million in benefits, irrespective of the number of contracts held by the contract owner or plan sponsor. If one or more unallocated annuity contracts are covered contracts under this part and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage must be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state, and in any event, the association is not obligated to cover more than $5 million in benefits with respect to all these unallocated contracts.

(2) The association is not obligated to cover more than:

(a) an aggregate of $300,000 in benefits with respect to any one life under subsections (1)(b)(i), (1)(b)(ii), and (1)(b)(iii), except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under subsection (1)(b)(i), in which case the aggregate liability of the association may not exceed $500,000 with respect to any one individual; and

(b) with respect to one owner of multiple nongroup policies of life insurance, whether the policyowner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, $5 million in benefits, regardless of the number of policies and contracts held by the owner.

(3) The limitations set forth in this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(4) In performing its obligations to provide coverage under this part, the association is not required to guarantee, assume, reinsure, or perform or cause to be guaranteed, assumed, reinsured, or performed the

contractual obligations of the impaired or insolvent insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract."

Section 18. Section 33-10-226, MCA, is amended to read:

"33-10-226. Distribution of ownership rights -- distribution to shareholders. (1) Prior to the termination of any liquidation, rehabilitation, or supervision proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policyowners of the impaired or insolvent insurer and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of ~~such~~ the impaired or insolvent insurer. In ~~such a~~ the determination, consideration ~~shall~~ must be given to the welfare of the ~~policyholders~~ policyowners of the continuing or successor insurer.

(2) ~~No~~ A distribution to stockholders, if any, of an impaired or insolvent insurer ~~shall~~ may not be made until and unless the total amount of assessments levied by the association with respect to ~~such~~ the insurer have been fully recovered by the association."

Section 19. Section 33-10-227, MCA, is amended to read:

"33-10-227. Assessments -- abatement -- basis for ratesetting. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at the times and for the amounts as the board finds necessary. The board shall collect the assessments after 30 days' written notice to the member insurers before payment is due.

(2) There are two classes of assessments, as follows:

(a) Class A assessments must be made for the purpose of meeting administrative costs and other general expenses not related to a particular impaired or insolvent insurer.

(b) Class B assessments must be made to the extent necessary to carry out the powers and duties of the association under 33-10-219 and 33-10-220~~(1)~~ with regard to an impaired or insolvent insurer.

(3) (a) The amount of any Class A assessment for each account must be determined by the board. The amount of any Class B assessment must be divided among the accounts in the proportion that the premiums received by the impaired or insolvent insurer on the policies covered by each account bear to the premiums received by the insurer on all covered policies.

(b) Class B assessments against member insurers for each account must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each

account bear to the premiums received on business in this state by all assessed member insurers.

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

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. The total of all assessments upon a member insurer for each account may not in any ~~one~~ 1 calendar year exceed 2% of the insurer's premiums in this state on the policies covered by the account.

(5) In the event an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth in subsection (4), the amount by which the assessment is abated or deferred must be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. If the maximum assessment, together with the other assets of the association in either account, does not provide in any ~~one~~ 1 year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon ~~thereafter~~ after that year as permitted by this part.

(6) If a 1% assessment for any subaccount of the life insurance account and the annuity account in any 1 year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (3)(b), the board shall assess all subaccounts of the life insurance account and the annuity account for the necessary additional amount, subject to the maximum assessment stated in subsection (4).

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

(8) It is proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(9) The association shall issue to each insurer paying an assessment under this part a certificate of contribution, in a form prescribed by the commissioner, for the amount paid. All outstanding certificates must be

of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in that form and for the amount, if any, and period of time that the commissioner may approve."

NEW SECTION. **Section 20. Codification instruction.** [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 10, part 2, and the provisions of Title 33, chapter 10, part 2, apply to [sections 1 and 2].

NEW SECTION. **Section 21. Effective date.** [This act] is effective July 1, 2003.

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