AN ACT REVISING THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND INCORPORATING MODEL ACT LANGUAGE; CLARIFYING APPLICABILITY TO IMPAIRED AND INSOLVENT INSURERS; REVISING THE POWERS AND DUTIES OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION; PROVIDING 60 DAYS FOR THE COMMISSIONER TO DISAPPROVE THE ASSOCIATION'S PLAN OF OPERATION OR AMENDMENTS TO THE PLAN; ELIMINATING CERTAIN REPORTING REQUIREMENTS; CHANGING THE STAY OF PROCEEDINGS AGAINST AN INSOLVENT INSURER TO 180 DAYS FROM 60 DAYS; CLARIFYING COVERAGE LIMITS AND INCREASING CERTAIN LIMITS; ALLOWING APPLICATION TO A RECEIVERSHIP COURT FOR DISBURSEMENT OF AN INSOLVENT INSURER'S ASSETS; PROHIBITING DISTRIBUTIONS TO STOCKHOLDERS OR OWNERS OF IMPAIRED OR INSOLVENT INSURERS UNTIL VALID CLAIMS ARE PAID WITH INTEREST; REQUIRING AT LEAST 180 DAYS' NOTICE OF AUTHORIZED ASSESSMENTS AND REVISING THE ASSESSMENT PROCESS; INCORPORATING EXISTING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-10-201, 33-10-202, 33-10-205, 33-10-210, 33-10-216, 33-10-217, 33-10-222, 33-10-223, 33-10-224, 33-10-225, 33-10-226, AND 33-10-227, MCA; REPEALING SECTIONS 33-10-219, 33-10-220, AND 33-10-228, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND APPLICABILITY DATE.

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

Section 1. 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 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 annuities, lottery 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 (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), 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.~~

~~(10) This part does not 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 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, 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 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, experience rating credits, or voting rights or provides that any fees or allowances be paid to any person, including the policyowner or contract 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;~~

~~(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.~~

~~(11)~~(4) This part must be liberally construed to effect the purpose under subsections (2) and (3), which constitute an aid and guide to interpretation.

~~(12)~~(5) 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 2. 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) "Authorized assessment" or "authorized" when used in the context of assessments means a specified

amount of money authorized for collection from member insurers by a resolution of the board of directors, established in 33-10-204. The authorized assessment may be called for immediately or in the future. The assessment is authorized when the board passes the resolution.

~~(3)~~(4) "Benefit plan" means a benefit plan for a specific employee, union, or association of natural persons ~~benefit plan~~.

(5) "Called", when used in the context of assessments, means that the association has issued a notice to member insurers requiring that an authorized assessment be paid within the timeframe set forth within the notice. An authorized assessment becomes a called assessment when the association mails the notice to member insurers.

~~(4)~~(6) "Contractual obligation" means ~~any~~ an obligation under ~~covered policies~~ any of the following for which coverage is provided in this part:

(a) a policy or contract;

(b) a certificate under a group policy or contract; or

(c) a portion of a policy or contract or a portion of a certificate.

~~(5)~~(7) "Covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided within the scope of this part ~~under 33-10-201(4) through (10)~~.

(8) "Extracontractual claims" includes but is not limited to those claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney fees and costs.

~~(6)~~(9) "Impaired insurer" means 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)~~(10) "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.

~~(8)~~(11) (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~~ this part and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The term does not include:

(i) a health service corporation;

(ii) a hospital or medical service organization, whether for profit or not for profit;

~~(ii)~~(iii) a health maintenance organization;

~~(iii)~~(iv) a fraternal benefit society;

~~(iv)~~(v) a mandatory state pooling plan;

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

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

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

~~(viii)~~(ix) an entity similar to any of the entities listed in subsections ~~(8)(b)(i)~~ (11)(b)(i) through ~~(8)(b)(vii)~~ (11)(b)(viii).

~~(9)~~(12) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or its successor.

~~(10)~~(13) (a) "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.

(b) The terms do not include a person with a mere beneficial interest in a policy or a contract.

~~(11)~~(14) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

~~(12)~~(15) "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.

~~(13)~~(16) (a) "Premiums" means 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)~~ this part, except that an assessable premium may not be reduced based on ~~33-10-201(10)(c)~~ 33-10-224(2)(b) relating to interest limitations and 33-10-224(3)(b) 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

(iii) 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, regardless of the number of policies or contracts held by the owner.

~~(14)~~(17) "Principal place of business" ~~of a plan sponsor~~ means:

(a) in the case of a plan sponsor, 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)~~(b) if 50% of the participants of a benefit plan are not employed in a single state and for a person other than an individual, the single state in which the individuals who establish policies for the direction, control, and coordination of the operations of the ~~plan sponsor~~ entity 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~~ their 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; or

(c) with respect to a plan sponsor defined in subsection (15)(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 that, in lieu of specific or clear designation of a principal place of business, is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

~~(15)~~(18) "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.

~~(16)~~(19) "Resident" means a person to whom a contractual obligation is owed and who resides in this state ~~at the time that the impairment is determined and to whom contractual obligations are owed~~ on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. 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.

(20) "State" means a state, the District of Columbia, the Commonwealth of Puerto Rico, or a United States possession, territory, or protectorate.

~~(17)~~(21) "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)~~(22) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

~~(19)~~(23) "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 3. Section 33-10-205, MCA, is amended to read:

"33-10-205. ~~General powers~~ Powers and duties of association ~~-- standing~~. (1) If a member insurer is an impaired insurer, the association, in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner, may:

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

(b) provide any money, pledges, loans, notes, guarantees, or other means to effectuate this section and ensure payment of the contractual obligations of the impaired insurer pending action under this section.

(2) If a member insurer is an insolvent insurer, the association, in its discretion, shall do one or more of the following:

(a) (i) guarantee, assume, or reinsure the policies or contracts of the insolvent insurer or cause the policies or contracts to be guaranteed, assumed, or reinsured or ensure payment of the contractual obligations of the insolvent insurer; and

(ii) provide money, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties;

(b) provide coverage and benefits with respect to a covered policy or contract for life or health insurance or annuities by:

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

(A) for group policies or contracts by not later than the earlier of the next renewal date, as specified in the policy or contract, or 45 days; or

(B) for nongroup policies, contracts, or annuities by the earlier of the next renewal date, if any, as specified in the policy or contract, or 1 year;

(ii) ensuring payment under subsection (2)(b)(i) not less than 30 days from the date on which the association becomes obligated with respect to the policies or contracts;

(iii) making diligent efforts to provide all known insureds and annuitants for nongroup policies and contracts or group policyowners with respect to group policies 30 days' notice of termination; and

(iv) (A) making available substitute coverage on an individual basis, with respect to nongroup life and health insurance policies and annuities covered by the association, to each known insured or annuitant or owner if other than the insured or annuitant and to an individual formerly insured or formerly an annuitant under a group policy if that individual is not eligible for replacement group coverage. This subsection (2)(b)(iv)(A) must be applied in accordance with the provisions of subsection (2)(b)(iv)(B), as applicable, if the insureds or annuitants had a right under law or if the terminated policy or annuity contained provisions to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or a specified time, during which the insurer had no right to unilaterally make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

(B) providing the substitute coverage required under subsection (2)(b)(iv)(A) either by issuing an alternative policy as provided in subsection (2)(b)(iv)(C) or reissuing the terminated coverage, as provided in subsection (2)(b)(iv)(D). Any reissued or alternative policy must be offered without requiring evidence of insurability and may not require a waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure any reissued or alternative policy.

(C) submitting alternative policies adopted by the association to the commissioner or the receivership court for approval. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency. 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 adopted by the association. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured. The premium may not reflect any changes in the health of the insured after the original policy was last underwritten. Alternative policies issued by the association must provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(D) setting a premium at a premium different from that charged under the terminated policy if the association elects to reissue terminated coverage. The association shall set the premium in accordance with the amount of insurance provided and the age and class of risk. The premium is subject to approval by the commissioner. A premium may also be set by a court of competent jurisdiction.

(c) cease any of its obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy on the date the coverage or policy is replaced by another similar policy by the policyowner, the insured, or the association; or

(d) ensure the payment or crediting of a rate of interest consistent with 33-10-224(2)(b)(iii) when proceeding under this section with respect to a policy or contract carrying guaranteed minimum interest rates.

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

(4) 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. The association is liable only for unearned premiums due to policyowners or contract owners arising after the entry of the order of liquidation.

(5) If the association fails to act within a reasonable period of time, the commissioner has the powers and duties of the association under this part with respect to a domestic, foreign, or alien insolvent insurer.

(6) In carrying out its duties under subsections (1) through (4), the association may, subject to approval by a court of competent jurisdiction, impose:

(a) permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement if the association finds that:

(i) the amounts that can be assessed under this part are less than the amounts needed to ensure full and prompt performance of the association's duties under this part; or

(ii) the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of permanent policy or contract liens to be in the public interest; or

(b) (i) temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts. This subsection (6)(b)(i) also allows temporary moratoriums or liens on any contractual provisions for deferral of cash or policy loan value.

(ii) If the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights for the period of the moratorium or moratorium charge imposed by the receivership court.

This subsection (6)(b)(ii) does not apply to claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) The association is not liable under this part for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides protection by statute or regulation for residents of this state if that protection is substantially similar to that provided by this part for residents of other states.

(8) 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 for calculating returns or changes in value. The alternative policy or contract issued under this subsection (8):

(a) must provide in lieu of the index or other external reference in the original policy or contract:

(i) a fixed interest rate;

(ii) payment of dividends within minimum guarantees; or

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

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

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

~~(1)~~(9) In addition to other rights provided by law, the association may:

(a) enter into contracts 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~~ to recover ~~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 must be legal investments for domestic insurers and may be carried as admitted assets.

(d) employ or retain persons who are necessary to handle the financial transactions of the association and to perform other functions 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 legal action that may be necessary or appropriate to avoid or recover 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 the association may not ~~in any case~~ issue insurance policies or annuity contracts other than those issued to perform ~~the contractual~~ its obligations ~~of the impaired or insolvent insurer~~ under this part;

(h) organize itself as a corporation or in any other legal form permitted by the laws of the state;

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

~~(2)~~(10) The association may render assistance and advice to the commissioner, upon request, concerning rehabilitation, liquidation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

~~(3)~~(11) The association has standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part or before any court with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. The association's standing 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 or contracts of the impaired or insolvent insurer and the determination of the covered policies ~~and contractual obligations~~ or contracts. The association ~~shall~~ also ~~have~~ has 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~~ which the association may have rights through subrogation or otherwise.

(12) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

~~(4)~~(13) 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)~~(14) 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)~~(15) Venue in a suit against the association arising under this part is in the first judicial district of this state. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

(16) 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 impaired or insolvent insurer that is other than this state."

Section 4. Section 33-10-210, MCA, is amended to read:

"33-10-210. Unfair trade practice -- notice to 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) 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~~ a member insurer may not deliver a policy or contract described in ~~33-10-201(4)~~ 33-10-224(2)(a) to a policyowner or contract owner unless the document is delivered to the policyowner or contract 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 policyowner. The distribution, delivery, contents, or interpretation of this document does not mean that either the policy or the contract or the 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 policyowner, contract 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 policyowner or contract 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 policyowner or contract 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 an insurance producer may not deliver a policy or contract described in ~~33-10-201(4)~~ 33-10-224(2)(a) and excluded under ~~33-10-201(10)~~ 33-10-224(2)(b) from coverage under this part unless the insurer or insurance producer, prior to or at the time of delivery, gives the policyowner or contract 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 5. Section 33-10-216, MCA, is amended to read:

"33-10-216. Plan of operation -- delegation of powers provision. (1) (a) The association shall submit to the commissioner a plan of operation and any amendments ~~thereto~~ to the plan that are necessary or suitable to ~~assure~~ ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments ~~thereto shall~~ to the plan become effective upon the commissioner's written approval ~~in writing by the commissioner~~ or 60 days after receipt by the commissioner's office if the commissioner does not disapprove the submitted plan of operation and any amendments within those 60 days.

(b) If the association fails to submit ~~a suitable plan of operation within 180 days following July 1, 1974, or if at any time thereafter the association fails to submit~~ suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate ~~such~~ reasonable rules ~~as are~~ necessary or advisable to effectuate the provisions of this part. ~~Such~~ The rules ~~shall continue~~ remain in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation ~~shall~~ must, in addition to requirements enumerated elsewhere in this part:

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

(b) establish the amount and method of reimbursing members of the board of directors under 33-10-204;

(c) establish regular places and times for meetings of the board of directors;

(d) establish procedures for keeping records ~~to be kept~~ of all financial transactions of the association, its ~~insurance producers~~ agents, and the board of directors;

(e) establish ~~the~~ procedures ~~whereby selections for~~ to select the board of directors ~~will be made~~ and ~~submitted~~ submit notice of the selections to the commissioner;

(f) establish any additional procedures for assessments under 33-10-227;

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

(4) The plan of operation may provide that any or all powers and duties of the association, except those under ~~33-10-205(1)(c)~~ 33-10-205(9)(c) and 33-10-227, ~~are~~ may be delegated to a corporation, association, or other organization ~~which~~ that performs or will perform functions similar to those of this association or its equivalent in two or more states. ~~Such a~~ A corporation, association, or organization ~~shall~~ to which these powers and duties are delegated must be reimbursed for any payments made on behalf of the association and ~~shall~~ must be paid for ~~its performance of~~ performing any function of the association. A delegation of authority under this subsection ~~shall~~ may take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization ~~which~~ that extends protection not substantially less favorable ~~and~~ or less effective than that provided by this part."

Section 6. 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 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 makes the report or information public.

(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 7. 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 must be stayed ~~60~~ 180 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 the judgment set aside by the same court that made the judgment and must be permitted to defend against the suit on the merits."

Section 8. Section 33-10-223, MCA, is amended to read:

"33-10-223. Assignment by beneficiaries -- subrogation. (1) Any person receiving benefits under this part must be considered to have assigned 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 the rights by any payee, 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 the person. The association must be subrogated to these rights against the assets of any impaired or insolvent insurer.

(2) The subrogation rights of the association under this section have the same priority against the assets

of the impaired or insolvent 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 or payment for 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 9. Section 33-10-224, MCA, is amended to read:

"33-10-224. ~~Extent~~ Coverage, limitations, and extent of liability. (1) (a) This part establishes coverage for the policies and contracts specified in subsection (2) to persons who, except as provided in subsections (1)(b) through (1)(e), are:

(i) beneficiaries, assignees, or payees of the persons covered under subsection (1)(a)(ii) regardless of where the beneficiaries, assignees, or payees reside, except for nonresident certificate holders under group policies or contracts;

(ii) owners of or certificate holders under the policies and contracts specified in subsection (2), other than unallocated annuity contracts and structured settlement annuities that are provided for in subsections (1)(b) and (1)(c), if the persons are:

(A) residents; or

(B) nonresidents, but only under all of the following conditions:

(I) the insurer that issued the policies is domiciled in this state;

(II) the state in which the person resides has an association similar to the association created under this part; and

(III) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(b) The provisions of subsection (1)(a) do not apply to unallocated annuity contracts specified in subsection (2). A person who is the owner of an unallocated annuity contract receives coverage under this part, except as provided in subsections (1)(d) and (1)(e), if:

(i) the contract is issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; or

(ii) the unallocated annuity contract was issued to or in connection with a government lottery if the owner is a resident.

(c) The provisions of subsection (1)(a) do not apply to structured settlement annuities specified in subsection (2). A person who is a payee under a structured settlement annuity or the beneficiary of a payee if the payee is deceased receives coverage under this part, except as provided in subsections (1)(d) and (1)(e), if the payee:

(i) is a resident, regardless of where the contract owner resides; or

(ii) is not a resident and one of the following conditions applies:

(A) The contract owner of the structured settlement annuity is a resident and is not eligible for coverage by another state's association, and the payee or beneficiary is not eligible for coverage by the association of the state in which the payee or beneficiary resides.

(B) The contract owner of the structured settlement annuity is not a resident, the insurer that issued the structured settlement annuity is domiciled in this state, the state in which the contract owner resides has an association similar to the association created by this part, and the payee, beneficiary, and contract owner are not eligible for coverage by the association in the state in which the payee, beneficiary, or contract owner resides.

(d) This part does not provide coverage to:

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

(ii) a person covered under subsection (1)(b) if any coverage is provided by the association of another state to the person.

(e) This part is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, a person may not receive coverage under this part if the person who would otherwise receive coverage under this part receives coverage under the laws of any other state. To determine the application of this subsection (1)(e) to a situation in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this part must be construed in conjunction with other state laws to result in coverage by only one association.

(2) (a) (i) Except as otherwise provided in this part, this part provides coverage to the persons specified in subsection (1) for:

(A) direct, nongroup life and health policies, direct, nongroup annuity contracts, and supplemental contracts to any of these;

(B) certificates under direct group policies and contracts and supplemental contracts to any of these; and

(C) unallocated annuity contracts issued by member insurers.

(ii) Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued in connection with government lotteries, and any immediate or deferred annuity contracts.

(b) This part does not provide coverage for:

(i) a portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract owner;

(ii) a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

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

(A) when averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this part exceeds the rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average that is averaged for that same period or for a lesser

period if the policy or contract was issued less than 4 years before the member insurer became an impaired or insolvent insurer under this part; and

(B) when the returns or changes in value exceed the rate of interest determined by subtracting 3 percentage points from the Moody's corporate bond yield average most recently available on or after the date on which the member insurer becomes an impaired or insolvent insurer under this part.

(iv) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, 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 other person under:

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. 1002;

(B) a minimum premium group insurance plan;

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

(D) an administrative services-only contract;

(v) a portion of a policy or contract to the extent that it contains provisions for dividends, experience rating credits, or voting rights or for payment of any fees or allowances to any person, including the policyowner or contract owner, in connection with the service to or administration of the policy or contract;

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

(vii) any unallocated annuity contract issued to or in connection with a benefit plan that is protected under the federal pension benefit guaranty corporation, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) a 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;

(ix) a portion of a policy or contract to the extent that federal or state law preempts or otherwise does not permit the assessments required by 33-10-227 with respect to the policy or contract;

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

(A) claims based on marketing materials;

(B) 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;

(C) misrepresentation of or regarding policy benefits;

(D) extracontractual claims; or

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

(xi) a contractual agreement that establishes the member insurer's obligation 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 may not be an affiliate of the member insurer;

(xii) a portion of a policy or contract to the extent that 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 change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of the impairment or insolvency of the member insurer, and the interest or changes in value are not subject to forfeiture.

(xiii) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to 42 U.S.C. 1395w-21 through 1395w-152, commonly known as medicare parts C and D, or any regulations issued pursuant to medicare parts C and D.

~~(1)~~(3) The benefits for which the association may become liable may not exceed the lesser of:

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

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

(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;

(B) 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 income insurance ~~as defined in the covered policy or contract~~;

(III) $300,000 for long-term care insurance;

~~(III)~~(IV) $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)~~ subsections (3)(b)(i)(B)(I) through (3)(b)(i)(B)(III);

(C) ~~$100,000~~ $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(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~~ $250,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

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

~~(iv)~~(iii) with respect to each payee of a structured settlement annuity or beneficiary of the payee if the payee is deceased, ~~$100,000~~ $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

~~(v)~~(iv) with respect to either one contract owner provided coverage under ~~33-10-201(6)~~ subsection (1)(b) or one plan sponsor whose ~~plans own~~ plan owns directly or in trust one or more unallocated annuity contracts not included in subsection ~~(1)(b)(ii)~~ (3)(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~~. In no event~~,~~ is the association ~~is not~~ obligated to cover more than $5 million in benefits with respect to all these unallocated contracts.

~~(2)~~(4) ~~The~~ In no event is 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)~~ (3)(b)(i) through (3)(b)(iii), except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under subsection ~~(1)(b)(i)~~ (3)(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)~~(5) 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)~~(6) 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 10. Section 33-10-225, MCA, is amended to read:

"33-10-225. Association as creditor -- use of assets. (1) For the purpose of carrying out its obligations under this part, the association ~~shall be deemed to be~~ is a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to 33-10-223.

(2) All assets of the impaired or insolvent insurer attributable to covered policies ~~shall~~ must be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this part. Assets attributable to covered policies, as used in this section, is that proportion of the assets which the reserves that should have been established for such policies bear to the reserve that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(3) As a creditor of the impaired or insolvent insurer, as established in this part and consistent with 33-2-1363, the association and other similar associations are entitled to receive a disbursement of assets out of the marshalled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this part. If, within 120 days of the receivership court issuing a final determination of insolvency of an insurer, the liquidator has not made an application to the court for the approval of a proposal to disburse assets out of marshalled assets to guaranty associations having obligations because of the

insolvency, then the association may make application to the receivership court for approval of its own proposal to disburse those assets."

Section 11. 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 the impaired or insolvent insurer. In the determination, consideration must be given to the welfare of the policyowners of the continuing or successor insurer.

(2) A distribution to stockholders, if any, of an impaired or insolvent insurer may not be made until and unless the association has fully recovered the total amount of ~~assessments levied by the association with respect to the insurer have been fully recovered by the association~~ valid claims of the association, with interest, for funds expended in carrying out its powers and duties under this part."

Section 12. 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) Assessments are due not less than 30 days after prior written notice to the member insurers. An unpaid assessment accrues interest at 10% a year on and after the due date. The association may also impose any charges on a late-paid assessment if the plan of operation provides for late-paid assessments.

~~(2)~~(3) There are two classes of assessments~~, as follows~~:

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

(b) Class B assessments must be ~~made~~ authorized and called to the extent necessary to carry out the

powers and duties of the association under ~~33-10-219 and 33-10-220~~ 33-10-205 with regard to an impaired or insolvent insurer.

~~(3)~~(4) (a) The amount of any Class A assessment for each account must be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the amount be credited against future Class B assessments. The total of all non-pro rata assessments may not exceed $300 for each member insurer in any 1 calendar year. The amount of any Class B assessment must be ~~divided~~ allocated for assessment purposes 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~~ pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard determined by the board in its sole discretion as being fair and reasonable under the circumstances.

(b) Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account or subaccount bear to the premiums received on business in this state by all assessed member insurers. This ratio must be calculated from information that is available for the 3 most recent calendar years preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the 3 most recent calendar years for which information is available preceding the year in which the insurer became impaired.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be ~~made~~ authorized and called until necessary to implement the purposes of this part. Classification of assessments under subsection ~~(2)~~ (3) and computation of assessments under this subsection (4) must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

~~(4)~~(5) 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 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~~ may 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 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 after that year as permitted by this part.~~ Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(6) (a) (i) Subject to the provisions of subsection (6)(a)(ii), the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account may not in 1 calendar year exceed 2% of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the 3 calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(ii) If two or more assessments are authorized in 1 calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subsection (6)(a)(i) must be equal and limited to the higher of the 3-year average annual premiums for the applicable account or subaccount as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in 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 as permitted by this part.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, for use when the board determines that the maximum assessment is insufficient to cover anticipated claims.

~~(6)~~(c) If ~~a 1%~~ the maximum assessment for ~~any~~ a 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)~~ (4)(b), the board shall assess ~~all~~ the other subaccounts of the life insurance ~~account~~ and ~~the~~ annuity account for the necessary additional amount, subject to the maximum assessment stated in subsection ~~(4)~~ (6)(a).

(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~~ account, including assets accruing from assignment, subrogation, and 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.

(10) (a) A member insurer that wishes to protest all or a part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. A written statement must accompany the payment and must indicate that the payment is made under protest and include a brief description of the grounds for the protest.

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

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

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

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

actually earned by the association.

(11) The association may request information of member insurers to aid in the exercise of its powers and duties under this section. Member insurers shall promptly comply with a request from the association."

Section 13. Repealer. The following sections of the Montana Code Annotated are repealed:

33-10-219. Impaired insurer -- association's powers.

33-10-220. Insolvent insurer -- association's powers.

33-10-228. Suspension for failure to pay -- forfeiture -- appeal from board actions.

Section 14. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 15. Effective date -- applicability. [This act] is effective on passage and approval and applies to proceedings in which a member insurer is placed under an order of liquidation with a finding of insolvency on or after [the effective date of this act].

- END -

I hereby certify that the within bill,

SB 0078, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day

of _____, 2011.

Speaker of the House

Signed this _____ day

of _____, 2011.

SENATE BILL NO. 78

INTRODUCED BY R. RIPLEY

BY REQUEST OF THE STATE AUDITOR

AN ACT REVISING THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND INCORPORATING MODEL ACT LANGUAGE; CLARIFYING APPLICABILITY TO IMPAIRED AND INSOLVENT INSURERS; REVISING THE POWERS AND DUTIES OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION; PROVIDING 60 DAYS FOR THE COMMISSIONER TO DISAPPROVE THE ASSOCIATION'S PLAN OF OPERATION OR AMENDMENTS TO THE PLAN; ELIMINATING CERTAIN REPORTING REQUIREMENTS; CHANGING THE STAY OF PROCEEDINGS AGAINST AN INSOLVENT INSURER TO 180 DAYS FROM 60 DAYS; CLARIFYING COVERAGE LIMITS AND INCREASING CERTAIN LIMITS; ALLOWING APPLICATION TO A RECEIVERSHIP COURT FOR DISBURSEMENT OF AN INSOLVENT INSURER'S ASSETS; PROHIBITING DISTRIBUTIONS TO STOCKHOLDERS OR OWNERS OF IMPAIRED OR INSOLVENT INSURERS UNTIL VALID CLAIMS ARE PAID WITH INTEREST; REQUIRING AT LEAST 180 DAYS' NOTICE OF AUTHORIZED ASSESSMENTS AND REVISING THE ASSESSMENT PROCESS; INCORPORATING EXISTING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-10-201, 33-10-202, 33-10-205, 33-10-210, 33-10-216, 33-10-217, 33-10-222, 33-10-223, 33-10-224, 33-10-225, 33-10-226, AND 33-10-227, MCA; REPEALING SECTIONS 33-10-219, 33-10-220, AND 33-10-228, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND APPLICABILITY DATE.