APPROVED
APRIL 12, 2018
BY GOVERNOR

CHAPTER
382
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND EIGHTEEN

S.P. 718 - L.D. 1875

An Act To Amend the Maine Life and Health Insurance Guaranty Association Act

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §4386, sub-§1, as enacted by PL 1981, c. 347, is amended to read:

1. Insolvency; assets disbursed. Within 120 days ~~of~~ after a final determination of insolvency of a company by a court of competent jurisdiction of this State, the receiver shall make application to the court for approval of a proposal to disburse assets out of the company's marshaled assets, from time to time as those assets become available, to the Maine Insurance Guaranty Association, to the Maine Life and Health Insurance Guaranty Association and to any similar organization in another state. The Maine Insurance Guaranty Association, the Maine Life and Health Insurance Guaranty Association and any similar organizations in other states ~~shall be~~ are referred to, collectively, as the associations.

Sec. 2. 24-A MRSA §4603, sub-§1, as amended by PL 2005, c. 346, §2 and affected by §16, is further amended to read:

1. Application. This chapter applies to direct nongroup life insurance policies, health insurance policies, annuity contracts and contracts supplemental to life and health insurance policies and annuity contracts and to certificates under direct group life insurance policies, health insurance policies and annuity contracts, except as limited by this chapter. For the purposes of this chapter~~, annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.~~:

A. Health insurance policies include individual and group health maintenance organization enrollment contracts, and health maintenance organizations are considered to be health insurers;

B. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts; and

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

Sec. 3. 24-A MRSA §4603, sub-§1-A, as amended by PL 2005, c. 346, §2 and affected by §16, is further amended to read:

1-A. Persons covered. This chapter provides coverage for the policies and contracts specified in subsection 1:

A. To any person, regardless of where the person resides, except for a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee or payee, including a health care provider rendering services covered under a health insurance policy or certificate, of a person covered under paragraph B;

B. To any person who owns, or is a certificate holder or enrollee under, a policy or contract specified in subsection 1, other than a structured settlement annuity, who:

(1) Is a resident; or

(2) Is not a resident, if all the following conditions are met:

(a) The insurer that issued the policy or contract is domiciled in this State;

(b) The insurer never held a license or certificate of authority in the state in which the person resides;

(c) The state in which the person resides has an association similar to the Maine Life and Health Insurance Guaranty Association; and

(d) The person is not eligible for coverage by the association in that state; and

C. To any person who is a payee under a structured settlement annuity, or to a beneficiary or beneficiaries of a payee if the payee is deceased, if the payee:

(1) Is a resident, regardless of where the contract owner resides; or

(2) Is not a resident, if all of the conditions of either division (a) or (b) are met:

(a) The contract owner of the structured settlement annuity is a resident; or

(b) The contract owner of the structured settlement annuity is not a resident, but:

(i) The insurer that issued the structured settlement annuity is domiciled in this State;

(ii) The state in which the contract owner resides has an association similar to the association created by this chapter; and

(iii) The payee or beneficiary and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

This chapter does not provide coverage to a person who is a payee or beneficiary of a contract owner who is a resident of this State if the payee or beneficiary is afforded any coverage by a similar association of another state.

This chapter is intended to provide coverage to a person who is a resident, and, in special circumstances as provided by this section, to a person who is not a resident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, that person may not be provided coverage under this chapter. In determining the application of the provisions of this subsection in a situation in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, enrollee or assignee, this chapter must be construed in conjunction with other state laws to result in coverage by only one association.

Sec. 4. 24-A MRSA §4603, sub-§2, ¶E, as amended by PL 2005, c. 346, §2 and affected by §16, is further amended to read:

E. ~~Any~~ With the exception of a policy or contract or portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits, any portion of a policy or contract to the extent that the rate of interest on which it is based, 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:

(1) Averaged over a period of 4 years before the date on which the member insurer becomes an impaired insurer or becomes an insolvent insurer under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged over the same 4-year period or for a lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired insurer or becomes an insolvent insurer, whichever is earlier; and

(2) On or after the date on which the member insurer becomes an impaired insurer or becomes an insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's Corporate Bond Yield Average as most recently available;

Sec. 5. 24-A MRSA §4603, sub-§2, ¶J, as enacted by PL 2005, c. 346, §2 and affected by §16, is amended to read:

J. Any obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner ~~or~~, policy owner, enrollee or certificate holder, including without limitation:

(1) Claims based on marketing materials;

(2) Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable ~~policy~~ form filing or approval requirements;

(3) Misrepresentations of or regarding policy or contract benefits;

(4) Extra-contractual claims; or

(5) Claims for penalties or consequential or incidental damages;

Sec. 6. 24-A MRSA §4603, sub-§2, ¶L, as amended by PL 2009, c. 118, §1 and affected by §5, is further amended to read:

L. Any unallocated annuity contract, except any annuity, whether allocated or unallocated, issued to a governmental retirement benefit plan established under the United States Internal Revenue Code, 26 United States Code, Section 401, 403(b) or 457; ~~and~~

Sec. 7. 24-A MRSA §4603, sub-§2, ¶M, as enacted by PL 2005, c. 346, §2 and affected by §16, is amended to read:

M. Any 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 that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or becomes an insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, 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 impairment or insolvency, whichever is earlier, and will not be subject to forfeiture~~.~~; and

Sec. 8. 24-A MRSA §4603, sub-§2, ¶N is enacted to read:

N. Any policy or contract providing hospital, medical, prescription drug or other health care benefits pursuant to 42 United States Code, Chapter 7, Subchapter XVIII, Part C or D (2018), also known as Medicare Part C or D, or pursuant to 42 United States Code, Chapter 7, Subchapter XIX (2018), also known as Medicaid, or any regulations issued pursuant thereto.

Sec. 9. 24-A MRSA §4603, sub-§3, ¶A, as enacted by PL 2005, c. 346, §2 and affected by §16, is amended to read:

A. The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

Sec. 10. 24-A MRSA §4603, sub-§3, ¶B, as repealed and replaced by PL 2009, c. 652, Pt. A, §34, is amended to read:

B. With respect to one life, regardless of the number of policies or contracts:

(1) Three hundred thousand dollars in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(2) The following limits for health insurance benefits:

(a) Three hundred thousand dollars for coverages not defined as disability income insurance, long-term care insurance or ~~basic hospital, medical and surgical insurance or major medical insurance~~ health plans as defined in section 4301-A, subsection 7, including any net cash surrender and net cash withdrawal values;

(b) Three hundred thousand dollars for disability income and long-term care insurance; or

(c) Five hundred thousand dollars for ~~basic hospital, medical and surgical insurance or major medical insurance~~ health plans as defined in section 4301-A, subsection 7; or

(3) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

Sec. 11. 24-A MRSA §4603, sub-§4, ¶A, as enacted by PL 2005, c. 346, §2 and affected by §16, is amended to read:

A. An aggregate of $300,000 in benefits with respect to any one life under subsection 3, paragraph B except with respect to benefits for ~~basic hospital, medical and surgical insurance and major medical insurance~~ health plans under subsection 3, paragraph B, subparagraph (2), in which case the aggregate liability of the association may not exceed $500,000 with respect to any one individual; or

Sec. 12. 24-A MRSA §4603, sub-§6, as enacted by PL 2005, c. 346, §2 and affected by §16, is amended to read:

6. Material economic benefits; contractual obligations. In performing its obligations to provide coverage under section 4608, the association is not required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Sec. 13. 24-A MRSA §4605-A, sub-§§8, 12 and 14, as enacted by PL 2005, c. 346, §5 and affected by §16, are amended to read:

8. Covered policy or covered policy or contract. "Covered policy" or "covered policy or contract" means a policy or contract or portion of a policy or contract for which coverage is provided under section 4603.

12. Member insurer. "Member insurer" means an insurer or health maintenance organization that is licensed or that holds a certificate of authority to transact in this State any kind of insurance, annuity or health maintenance organization business for which coverage is provided under section 4603 and includes an insurer or health maintenance organization whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

A. A hospital or medical service organization, whether profit or nonprofit;

~~B. A health maintenance organization;~~

C. A fraternal benefit society;

D. A mandatory state pooling plan;

E. A mutual assessment company or other person that operates on an assessment basis;

F. An insurance exchange;

G. An organization that has a certificate or license limited to the issuance of charitable gift annuities under this Title; or

H. An entity similar to any of those listed in this subsection.

14. Owner. "Owner" with respect to a policy or contract and "policyholder," "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise 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 properly recorded as the owner on the books of the insurer. "Owner," "policyholder," "contract owner" and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

Sec. 14. 24-A MRSA §4606, sub-§1, as amended by PL 2005, c. 346, §6 and affected by §16, is further amended to read:

1. Creation. There is created a nonprofit legal entity to be known as the Maine Life and Health Insurance Guaranty Association. All member insurers must be and remain members of the association as a condition of their authority to transact insurance or health maintenance organization business in this State. The association shall perform its functions under the plan of operation established and approved under section 4610 and shall exercise its powers through a board of directors established under section 4607. For purposes of administration and assessment, the association shall maintain 3 accounts:

A. The health insurance account;

B. The life insurance account; and

C. The annuity account, which must include annuity contracts owned by a governmental retirement plan or its trustee established under Section 401, Section 403(b) or Section 457 of the United States Internal Revenue Code.

Sec. 15. 24-A MRSA §4607, sub-§1, as amended by PL 2005, c. 346, §6 and affected by §16, is further amended to read:

1. Membership. The board of directors of the association must consist of not less than ~~5~~ 7 nor more than ~~9~~ 11 members representing member insurers serving terms as established in the plan of operation pursuant to section 4610. The members of the board are selected by member insurers subject to the approval of the superintendent. Vacancies on the board must be filled for the remaining period of the term in the manner described in the plan of operation. To select the initial board of directors and initially organize the association, the superintendent shall give notice to all member insurers of the time and

place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer is entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the superintendent may appoint the initial members.

Sec. 16. 24-A MRSA §4608, sub-§1, ¶A, as amended by PL 2005, c. 346, §6 and affected by §16, is further amended to read:

A. Guarantee, assume, reissue or reinsure~~,~~ or cause to be guaranteed, assumed, reissued or reinsured all the covered policies of the impaired insurer; or

Sec. 17. 24-A MRSA §4608, sub-§3-A, ¶¶A and B, as enacted by PL 2005, c. 346, §6 and affected by §16, are amended to read:

A. Take the following actions:

(1) Guarantee, assume, reissue or reinsure or cause to be guaranteed, assumed, reissued or reinsured the policies or contracts of the insolvent insurer, or assure payment of the contractual obligations of the insolvent insurer; and

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

B. Provide benefits and coverages in accordance with this paragraph.

(1) With respect to life and health insurance policies and annuities, the association shall assure 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 or contracts of the insolvent insurer, for claims incurred:

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

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

(2) The association shall make diligent efforts to provide all known insureds, enrollees or annuitants for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, 30 days' notice of the termination of the benefits provided.

(3) With respect to nongroup life and health insurance policies and annuities covered by the association, the association shall make available to each known insured, enrollee or annuitant, or owner if other than the insured, enrollee or annuitant, and, with respect to an individual formerly insured, formerly enrolled or formerly an annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (4), if the insureds,

enrollees or annuitants had a right under law or the terminated policy or annuity 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 annuity or had a right only to make changes in premium by class.

(4) In providing substitute coverage, the association may offer either to reissue the terminated coverage or to issue an alternative policy in accordance with the following:

(a) Alternative or reissued 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;

(b) The association may reinsure any alternative or reissued policy;

(c) Alternative policies adopted by the association and any amendments to reissued policies are subject to the approval of the superintendent ~~and the receivership court~~. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

(d) 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~~ an actuarially justified table of rates that it adopts, subject to prior approval of the superintendent. 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; and

(e) Any alternative policy 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.

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

(6) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy must cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured, the enrollee or the association.

(7) When proceeding under this paragraph with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 4603.

(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 chapter 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 chapter.

(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 for unearned premiums due to policy or contract owners arising after the entry of the order.

(10) The protection provided by this chapter 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 other than this State.

Sec. 18. 24-A MRSA §4608, sub-§6-B, as enacted by PL 2005, c. 346, §6 and affected by §16, is amended to read:

6-B. Retention of deposit; final order of liquidation or rehabilitation plan. A deposit in this State, held pursuant to law or required by the superintendent for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of ~~an~~ a member insurer domiciled in this State or in a reciprocal state, pursuant to this Title must be promptly paid to the association. The association is entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this State related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association and not retained pursuant to this subsection. Any amount so paid to the association less the amount not retained by it must be treated as a distribution of estate assets pursuant to chapter 57 or similar provision of the state of domicile of the impaired or insolvent insurer.

Sec. 19. 24-A MRSA §4608, sub-§§8 and 9, as amended by PL 2005, c. 346, §6 and affected by §16, are further amended to read:

8. Standing to appear before court. The association has standing to appear or intervene before any court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise. This standing extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the covered policies or contracts and contractual obligations of the impaired or insolvent insurer and the determination of the covered policies or contracts and contractual obligations. The association also 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 with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

9. Subrogation rights. Any person receiving benefits under this chapter is deemed to have assigned that person's rights under, and any causes of action against any person

for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of these rights and cause of action by any payee, policy or contract owner, beneficiary, insured, enrollee or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon that person. The association is subrogated to these rights against the assets of any impaired or insolvent insurer.

The subrogation rights of the association under this subsection must 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 chapter.

In addition, 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, insured, enrollee 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 chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Section 130 of the federal Internal Revenue Code.

If the provisions of this subsection 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 policies or portion thereof covered by the association.

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

Sec. 20. 24-A MRSA §4608, sub-§11, ¶¶C and G, as amended by PL 2005, c. 346, §6 and affected by §16, are further amended to read:

C. Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default are legal investments for domestic member insurers and may be carried as admitted assets;

G. Exercise, for the purposes of this chapter and to the extent approved by the superintendent, the powers of a domestic life or health insurer or health maintenance organization, but in no case may the association issue ~~insurance~~ policies or ~~annuity~~ contracts other than those issued to perform the contractual obligations of the impaired insurer;

Sec. 21. 24-A MRSA §4608, sub-§11, ¶J, as enacted by PL 2005, c. 346, §6 and affected by §16, is amended to read:

J. 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; ~~and~~

Sec. 22. 24-A MRSA §4608, sub-§11, ¶J-1 is enacted to read:

J-1. In accordance with the terms and conditions of the policy or contract, if not otherwise prohibited by applicable law, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter; and

Sec. 23. 24-A MRSA §4608, sub-§12, ¶G, as enacted by PL 2005, c. 346, §6 and affected by §16, is amended to read:

G. Except as otherwise expressly provided, this subsection does not alter or modify the terms and conditions of the indemnity reinsurance agreements of an insolvent insurer. This subsection may not be construed to abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. This subsection may not be construed to give a policy owner, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

Sec. 24. 24-A MRSA §4608, sub-§16, as enacted by PL 2005, c. 346, §6 and affected by §16, is amended to read:

16. Issuance of substitute coverage. In carrying out its duties in connection with guaranteeing, assuming, reissuing or reinsuring policies or contracts under this section, the association may~~, subject to approval of the receivership court,~~ issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with this subsection.

A. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract must provide for:

(1) A fixed interest rate;

(2) Payment or dividends with minimum guarantees; or

(3) A different method for calculating interest or changes in value.

B. There may not be a requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract.

C. The alternative policy or contract must be substantially similar to the replaced policy or contract in all other material terms.

Sec. 25. 24-A MRSA §4609, sub-§3-A, as enacted by PL 2005, c. 346, §7 and affected by §16, is amended to read:

3-A. Determination of assessments. Assessments must be determined as follows:

A. The amount of any Class A assessment, as described in subsection 2-A, for each account must be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. ~~The amount of any Class B assessment, as described in subsection 2-A, must be allocated for assessment purposes among the accounts 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. This paragraph may not be a factor in the determination as to whether the protection provided by laws for residents of this State by the domiciliary jurisdiction of a foreign or alien insurer is or is not substantially similar to the protection provided by this chapter for residents of other states~~ If pro rata, it must be allocated in the same proportions as a Class B assessment under paragraph C, and the board has the power to credit it against future Class B assessments.

~~B. Class A assessments, as described in subsection 2-A, 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 or contracts covered by each account for the calendar year for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the calendar year for which information is available preceding the year in which the insurer became impaired bears to premiums received on business in this State for the calendar year by all assessed member insurers.~~

C. Class B assessments, as described in subsection 2-A, ~~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 or contracts covered by each account for the calendar year for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the calendar year for which information is available preceding the year in which the insurer became impaired bears to premiums received on business in this State for the calendar year by all assessed member insurers~~ must be allocated as follows.

(1) Except for assessments related to long-term care insurance that are subject to allocation under subparagraph (2), the amount of the assessment must be allocated among the accounts 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 of directors in its sole discretion as being fair and reasonable under the circumstances.

(2) The amount of any Class B assessment for liabilities arising out of long-term care insurance written by the impaired or insolvent insurer, if the impairment or insolvency is declared on or after July 1, 2018, must be allocated among the accounts according to a methodology included in the plan of operation and approved by the superintendent. The methodology must provide for 50% of the assessment to be allocated to member insurers that are health insurers and 50% to be allocated to member insurers that are life and annuity insurers.

(3) All Class B assessments must be allocated among member insurers within each account in the proportion that the premiums received by each assessed

member insurer, on business in this State covered by the account, bears to premiums received on such business by all assessed member insurers, for the most recent calendar year for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, preceding the year in which the insurer became impaired.

(4) Health maintenance organizations are not subject to Class B assessments arising out of impairments or insolvencies declared before July 1, 2018.

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

E. This subsection may not be a factor in determining whether the protection provided by laws for residents of this State by the domiciliary jurisdiction of a foreign or alien insurer is substantially similar to the protection provided by this chapter for residents of other states.

Sec. 26. 24-A MRSA §4611, sub-§2, as enacted by PL 1983, c. 846, is amended to read:

2. Suspension or revocation of certificate of authority. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact ~~insurance~~ business in this State of any member insurer ~~which~~ that fails to pay an assessment when due or fails to comply with the plan of operation. In lieu of such suspension or revocation, any member insurer ~~which~~ that fails to pay an assessment when due or fails to comply with the plan of operation may be punished by a fine not to exceed the greater of 5% of the unpaid assessment per month or $100 per month.

Sec. 27. 24-A MRSA §4612-A, sub-§§2 and 3, as enacted by PL 2005, c. 346, §11 and affected by §16, are amended to read:

2. Advice and recommendations. The superintendent may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the superintendent regarding the financial condition of member insurers and companies seeking admission to transact insurance or health maintenance organization business in this State.

3. Action by board of directors. The board of directors, upon majority ballot vote, shall:

A. Notify the superintendent of any information indicating that any member insurer may be ~~an~~ impaired or insolvent ~~insurer~~;

B. Make reports and recommendations to the superintendent upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do ~~an~~ insurance or

health maintenance organization business in this State. These reports and recommendations must be treated as confidential by the superintendent; and

C. Make recommendations to the superintendent for the detection and prevention of ~~insurer~~ insolvencies.

Sec. 28. 24-A MRSA §4614, sub-§4, ¶A, as amended by PL 2005, c. 346, §12 and affected by §16, is further amended to read:

A. Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders ~~and~~, policy owners, contract owners, certificate holders and enrollees 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 such a determination, consideration must be given to the welfare of the policy owners, contract owners, certificate holders and enrollees of the continuing or successor insurer.

Sec. 29. 24-A MRSA §4620, first ¶, as enacted by PL 2005, c. 346, §14 and affected by §16, is amended to read:

A person, including ~~an~~ a member insurer or an agent or affiliate of ~~an~~ a member insurer, may not make, publish, disseminate, circulate or place before the public or cause directly or indirectly to be made, published, disseminated, circulated or placed before the public in any newspaper, magazine or publication or in the form of a notice, circular, pamphlet, letter or poster or over any radio station or television station or in any other way any advertisement, announcement or statement, written or oral, that uses the existence of the association for the purpose of sales, solicitation or inducement to purchases of any form of insurance covered by this chapter. This section does not apply to the Maine Life and Health Insurance Guaranty Association or any other entity that does not sell or solicit insurance or health maintenance organization coverage.

Sec. 30. 24-A MRSA §4621, sub-§2-A is enacted to read:

2-A. Insurers not subject to premium tax. A member insurer that is not subject to premium taxation may take the credit allowed under subsection 1 against its income tax liability to this State. A member insurer that is exempt from both premium taxation and income taxation in this State may recoup its assessments by a surcharge on its premiums in an amount reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the superintendent. Amounts recouped are not considered premiums for any other purpose, including medical loss ratio calculations and premium-based assessments. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount must be applied to reduce future assessments in the appropriate account.