Act No. 671
Public Acts of 2006
Approved by the Governor
January 8, 2007
Filed with the Secretary of State
January 10, 2007
EFFECTIVE DATE: January 10, 2007

STATE OF MICHIGAN
93RD LEGISLATURE
REGULAR SESSION OF 2006

Introduced by Rep. Hune

ENROLLED HOUSE BILL No. 6313

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 (MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717), sections 7702, 7708, 7709, 7711, 7712, 7714, and 7717 as amended by 1989 PA 302, sections 7704, 7705, and 7706 as amended by 1996 PA 548, and section 7707 as added by 1982 PA 194, and by adding section 838a.

The People of the State of Michigan enact:

Sec. 838a. (1) As used in this section:

(a) "2001 CSO mortality table" means that term as defined in section 838.

(b) "2001 CSO preferred class structure mortality table" means mortality tables with separate rates of mortality for super preferred nonsmokers, preferred nonsmokers, residual standard nonsmokers, preferred smokers, and residual standard smoker splits of the 2001 CSO nonsmoker and smoker tables as adopted by the NAIC at the September 2006 national meeting and published in the "NAIC Proceedings" (3rd Quarter 2006). Unless the context indicates otherwise, the "2001 CSO preferred class structure mortality table" includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

(c) "NAIC" means the national association of insurance commissioners.

(d) "Smoker and nonsmoker mortality tables" means that term as defined in section 838.

(e) "Statistical agent" means an entity with proven systems for protecting the confidentiality of individual insured and insurer information; demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers, which are its members or subscribers; and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

(2) An insurer may, for each calendar year of issue for any 1 or more specified plans of insurance and subject to this section, substitute the 2001 CSO preferred class structure mortality table in place of the 2001 CSO smoker and nonsmoker mortality tables as the minimum valuation standard for policies issued on or after January 1, 2007. An insurer shall not elect the 2001 CSO preferred class structure mortality table until the insurer demonstrates that at least 20% of the business to be valued on this table is in 1 or more of the preferred classes. A table from the 2001 CSO preferred class structure mortality table used in place of a 2001 CSO mortality table as provided in this section shall be treated as part of the 2001 CSO mortality table only for purposes of reserve valuation pursuant to section 838.

(3) For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO mortality table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary shall certify both of the following:

(a) That the present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) That the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(4) For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO mortality table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify both of the following:

(a) That the present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

(b) That the present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

(5) Unless exempted by the commissioner, every authorized insurer using the 2001 CSO preferred class structure mortality table shall file annually with the commissioner, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the commissioner statistical reports showing mortality and such other information as the commissioner may consider necessary or expedient for the administration of this section. The form of the reports shall be established by the commissioner.

Sec. 7702. (1) The purpose of this chapter is to protect, subject to certain limitations, persons specified in section 7704(1) against failure in the performance of contractual obligations under insurance policies and annuity

contracts specified in section 7704(2) because of the impairment or insolvency of the insurer issuing the policies or contracts. To provide this protection:

(a) An association of insurers is created to enable the guaranty of payment of benefits and continuation of coverages as limited in this chapter.

(b) Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

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

(2) This chapter shall be construed to execute the purposes provided in subsection (1).

Sec. 7704. (1) This chapter shall provide coverage for the policies and contracts specified in subsection (2) to the following persons:

(a) To a person, other than nonresident certificate holders under group policies or contracts, who, regardless of where he or she resides, is the beneficiary, assignee, or payee of a person covered under subdivision (b).

(b) To a person who is an owner of, or certificate holder under, a policy or contract described in subsection (2), other than an unallocated annuity contract or structured settlement contract, and which owner or certificate holder is 1 of the following:

(*i*) A resident.

(*ii*) Not a resident, if all of the following conditions are met:

(A) The insurer that issued the policy or contract is domiciled in this state.

(B) The state in which the person resides has an association similar to the association created by this chapter.

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

(*iii*) Not a resident, if both of the following conditions are met:

(A) The person would have been considered a resident at the time the coverage was obtained by the person.

(B) The person is not eligible for coverage by another guaranty association.

(c) For an unallocated annuity contract, except as provided in subsection (3), to either of the following:

(*i*) To a person who is the owner of an unallocated annuity contract if the contract is issued to or in connection with a specific plan whose sponsor has its principal place of business in this state.

(*ii*) To a person who is the owner of an unallocated annuity contract issued to or in connection with a government lottery if the owner is a resident of this state.

(d) For a structured settlement annuity, except as provided in subsection (3), to a person who is a payee under a structured settlement annuity, or a beneficiary of a payee if the payee is deceased, and the payee is either of the following:

(*i*) A resident, regardless of where the contract owner resides.

(*ii*) Not a resident, if either of the following conditions is met:

(A) The contract owner of the structured settlement annuity is a resident, and the payee or beneficiary is not eligible for coverage from the association where the payee or beneficiary resides.

(B) The contract owner of the structured settlement annuity is not a resident, and both of the following conditions are met:

(I) The insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this chapter.

(II) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(2) Except as provided in subsections (3), (4), and (5), this chapter provides coverage to a person specified in subsection (1) for direct, nongroup life, health, annuity, and supplemental policies or contracts, for certificates under direct group life, health, annuity, and supplemental policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter.

(3) This chapter does not provide coverage to a person who is a payee or 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 to a person otherwise covered under subsection (1)(c), if any coverage is provided by the association of another state to that person.

(4) This chapter 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, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under

this chapter. In determining the application of the provisions of this chapter in situations where a person could be covered by the association of more than 1 state, whether as an owner, payee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only 1 association.

(5) This chapter does not provide coverage for the following:

(a) 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, including, but not limited to, the nonguaranteed portion of a variable or separate account product.

(b) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract.

(c) A 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 use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value exceeds the following:

(*i*) Averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first, the 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 a lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first.

(*ii*) On and after the date on which the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first, the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as most recently available.

(d) A portion of a plan 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 any of the following:

(*i*) A multiple employer welfare arrangement as defined in section 7001.

(*ii*) A minimum premium group insurance plan.

(*iii*) A stop-loss or excess-loss group insurance plan. This subparagraph does not apply to the insured portion of a stop-loss or excess-loss group insurance plan written pursuant to section 407a or 5208 or written by a member property casualty insurer if the premiums were identified as disability insurance premiums in its annual statement.

(*iv*) An administrative services only contract.

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

(f) A policy or contract issued in this state by an insurer at a time when it did not have a certificate of authority to issue the policy or contract in this state.

(g) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation regardless of whether the federal pension benefit guaranty corporation has become liable to make any payments with respect to the benefit plan.

(h) A portion of an 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 contract owner or policy owner, including, but not limited to, any of the following:

(*i*) A claim based on marketing materials.

(*ii*) A claim based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements.

(*iii*) A claim based on misrepresentations of or regarding policy benefits.

(*iv*) An award of exemplary or punitive damages or statutory interest and claims related to bad faith in the payment of claims, and attorney fees and costs.

(*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.

(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 policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first. 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 subdivision, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and is not subject to forfeiture.

(6) The benefits that the association may become obligated to cover shall not exceed the lesser of the following:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired insurer or an insolvent insurer.

(b) With respect to 1 life, regardless of the number of policies or contracts:

(*i*) $300,000.00 in life insurance death benefits, but not more than $100,000.00 in net cash surrender and net cash withdrawal values for life insurance.

(*ii*) Except as otherwise provided in subparagraphs (*iv*) and (*v*), $100,000.00 in health insurance benefits, including any net cash surrender and net cash withdrawal values.

(*iii*) $100,000.00 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; however, for an individual qualified retirement annuity, $250,000.00 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. As used in this subparagraph, "individual qualified retirement annuity" means an annuity issued to an individual or a custodian on behalf of the individual pursuant to section 408 or 408A of the internal revenue code of 1986, 26 USC 408 and 408A, or an annuity certificate issued to an individual pursuant to section 403(b) of the internal revenue code of 1986, 26 USC 403(b).

(*iv*) $300,000.00 in disability income insurance benefits or long-term care benefits.

(*v*) $500,000.00 in basic hospital, medical, and surgical insurance benefits.

(c) With respect to each individual participating in a governmental retirement benefit plan established under section 401(k), 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457, covered by an unallocated annuity contract or the beneficiaries of each such individual, if deceased, in the aggregate, $100,000.00 in present value annuity benefits, including net cash surrender and net cash withdrawal values.

(d) With respect to each payee of a structured settlement annuity, or the beneficiary or beneficiaries of a deceased payee, $100,000.00 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

(e) For either 1 contract owner provided coverage under subsection (1)(c)(*ii*) or 1 plan sponsor whose plans own directly or in trust 1 or more unallocated annuity contracts not included in subdivision (C), $5,000,000.00 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, if 1 or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall 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, but in no event is the association obligated to cover more than $5,000,000.00 in benefits for all those unallocated contracts.

(7) In no event is the association obligated to cover more than the following:

(a) An aggregate of $300,000.00 in benefits for any 1 life under subsection (6)(b)(*i*), (*ii*), (*iii*), and (*iv*), (c), and (d).

(b) An aggregate of $500,000.00 in benefits for any 1 life under subsection (6)(b)(*v*).

(c) For 1 owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, $5,000,000.00 in benefits, regardless of the number of policies and contracts held by the owner.

(8) The limitations under subsections (6) and (7) 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 insurer or insolvent insurer attributable to covered policies. The costs of the association's obligations under this act may be satisfied by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(9) In performing its obligations to provide coverage under section 7708, the association is not required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, contractual obligations of the insolvent insurer or impaired insurer under a covered policy or contract that do not materially affect the economic benefits of the covered policy or contract.

Sec. 7705. As used in this chapter:

(a) "Account" means either of the 2 accounts created under section 7706.

(b) "Association" means the Michigan life and health insurance guaranty association created under section 7706.

(c) "Authorized assessment" or "authorized" when used in the context of assessments means a resolution or motion passed by the association's board of directors that directs that an assessment be called immediately or in the future from member insurers for a specific amount. An assessment is authorized when the resolution or motion is passed.

(d) “Benefit plan” means a specific employee, union, or association of natural persons benefit plan.

(e) “Called assessment” or “called” when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) “Contractual obligation” means an obligation under covered policies.

(g) “Covered policy” means a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided under section 7704.

(h) “Health insurance” means disability insurance as defined in section 606.

(i) “Impaired insurer” means a member insurer considered by the commissioner after May 1, 1982, to be potentially unable to fulfill the insurer’s contractual obligations or that is placed under an order of rehabilitation or conservation by a court of competent jurisdiction. Impaired insurer does not mean an insolvent insurer.

(j) “Insolvent insurer” means a member insurer that after May 1, 1982, becomes insolvent and is placed under an order of liquidation, by a court of competent jurisdiction with a finding of insolvency.

(k) “Member insurer” means a person authorized to transact a kind of insurance or annuity business in this state for which coverage is provided under section 7704 and includes an insurer whose certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. Member insurer does not include the following:

(*i*) A fraternal benefit society.

(*ii*) A cooperative plan insurer authorized under chapter 64.

(*iii*) A health maintenance organization authorized or licensed under chapter 35.

(*iv*) A mandatory state pooling plan.

(*v*) A mutual assessment or any entity that operates on an assessment basis.

(*vi*) A nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(*vii*) A nonprofit health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(*viii*) An insurance exchange.

(*ix*) An organization that has a certificate or license limited to the issuance of charitable gift annuities.

(*x*) Any entity similar to the entities described in this subdivision.

(*l*) “Moody’s corporate bond yield average” means the monthly average corporates as published by Moody’s investors service, inc., or a successor to that service.

(m) “Owner” of a contract or policy and “contract owner” and “policy owner” mean the person who is identified as the legal owner under the terms of the contract or policy or who is otherwise vested with the legal title to the contract or policy through a valid assignment completed in accordance with the terms of the contract or policy and properly recorded as the owner on the books of the insurer. The terms owner, contract owner, and policy owner do not include persons with a mere beneficial interest in a contract or policy.

(n) “Person” means an individual, corporation, partnership, association, or voluntary organization.

(o) “Plan sponsor” means the following:

(*i*) For a benefit plan established or maintained by a single employer, the single employer.

(*ii*) For a benefit plan established or maintained by an employee organization, the employee or organization.

(*iii*) For a benefit plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 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.

(p) “Premiums” means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. The term “premiums” does not include an amount or consideration received for a policy or contract, or a portion of a policy or contract for which coverage is not provided under section 7704. However, accessible premiums shall not be reduced on account of sections 7704(5)(c) relating to interest limitations and 7704(6)(b), (c), and (e) relating to limitations with respect to any 1 individual, any 1 participant, and any 1 contract holder. Premiums shall not include premiums in excess of the following:

(*i*) $5,000,000.00 on an unallocated annuity contract not issued under a governmental retirement plan established under section 401(k), 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457.

(*ii*) For multiple nongroup policies of life insurance owned by 1 owner, whether the policyowner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, $5,000,000.00 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(q) "Principal place of business" of a plan sponsor or a person other than a natural person means the state in which the natural persons who establish policy for the direction, control, and coordination of the entity as a whole primarily exercise that function. In making this determination, the association, in its reasonable judgment, shall consider all of the following factors:

(*i*) The state in which the primary executive and administrative headquarters of the entity is located.

(*ii*) The state in which the principal office of the chief executive officer of the entity is located.

(*iii*) The state in which the board of directors, or the entity's similar governing person or persons, conducts the majority of its meetings.

(*iv*) The state in which the executive or management committee of the board of directors, or the entity's similar governing person or persons, conducts the majority of its meetings.

(*v*) The state from which the management of the overall operations of the entity is directed.

(*vi*) For 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 subparagraphs (*i*) to (*v*). However, for a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, that state is the principal place of business of the plan sponsor.

(*vii*) For a plan sponsor of a benefit plan, 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 shall be based upon the location of the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in lieu of a specific or clear designation of a principal place of business.

(r) "Receivership court" means the court in the insolvent insurer's or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(s) "Resident" means a person who resides in this state at the time a member insurer is determined to be an impaired insurer or insolvent insurer and to whom contractual obligations are owed. A person may be considered a resident of only 1 state, which in the case of a person other than a natural person, is its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of the United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter shall be considered residents of this state if the insurer that issued the policies or contracts is domiciled in this state.

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

(u) "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.

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

(w) "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 an annuity benefit guaranteed to an individual by an insurer under the contract or certificate. The term shall also include, but is not limited to, guaranteed investment contracts and deposit administration contracts.

Sec. 7706. (1) There is created a nonprofit legal entity to be known as the Michigan life and health insurance guaranty association. A member insurer shall be and remain a member of the association as a condition of authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 7710 and shall exercise its powers through a board of directors established under section 7707. For purposes of administration and assessment the association shall maintain the following 2 accounts:

(a) The health insurance account.

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

(*i*) A life insurance subaccount.

(*ii*) An annuity subaccount, which shall include unallocated annuity contracts owned by a governmental retirement plan, or its trustee, established under section 401, 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457, but shall not include other unallocated annuities.

(*iii*) An unallocated annuity subaccount, which shall not include unallocated annuity contracts owned by a governmental retirement benefit plan, or its trustee, established under section 401, 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457.

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

Sec. 7707. (1) The board of directors of the association shall consist of not less than 5 nor more than 9 member insurers and 2 persons representing the general public serving terms as established in the plan of operation. The 2 members of the board representing the general public shall be appointed by the commissioner, shall not be engaged in the business of insurance, and shall not be officers, directors, or employees of an insurance company. The remaining members of the board shall be elected by member insurers subject to the approval of the commissioner. A vacancy on the board for a member representing the general public shall be filled for the remaining period of the term by appointment by the commissioner. A vacancy on the board for a member representing member insurers shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To elect the initial board of directors, and initially organize the association, the commissioner 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 shall be entitled to 1 vote in person or by proxy.

(2) In approving an election or in appointing a member to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) A member of the board may be reimbursed from the assets of the association for expenses incurred by the member as a member of the board of directors but a member of the board shall not otherwise be compensated by the association for his or her services.

Sec. 7708. (1) In addition to the powers and duties enumerated in other sections of this chapter, the association has the powers and duties provided in this section.

(2) If a member insurer is an impaired insurer, the association, subject to conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner, may do any of the following:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurer.

(b) Provide money, pledges, notes, guarantees, or other means as are proper to effectuate subdivision (a), and to assure payment of the contractual obligations of the impaired insurer pending action under subdivision (a).

(c) Loan money to the impaired insurer.

(3) Subject to the conditions specified in subsection (4), if a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims timely, the association shall do either of the following:

(a) Take any of the actions specified in subsection (2).

(b) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition for them under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

(4) The association is subject to subsection (3) only if the following are met:

(a) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(*i*) The delinquency proceeding shall not be dismissed.

(*ii*) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management.

(*iii*) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored.

(b) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state.

(c) If the impaired insurer is a foreign or alien insurer, any of the following has occurred:

(*i*) It has been prohibited from soliciting or accepting new business in this state.

(*ii*) Its certificate of authority has been suspended or revoked in this state.

(*iii*) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of that state.

(5) If a member insurer is an insolvent insurer, the association shall do either of the following:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer; and provide money, pledges, notes, guarantees, or other means as are reasonably necessary to effectuate this subdivision.

(b) Provide benefits and coverage pursuant to subsection (6).

(6) If proceeding under subsection (3)(b) or (5)(b), all of the following apply:

(a) 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 as follows:

(*i*) For group policies or contracts, not later than the earlier of the next renewal date under the policy or contract or 45 days, but not less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts.

(*ii*) 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 or 1 year, but not less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts.

(b) The association shall make diligent efforts to provide all known insureds or annuitants of nongroup contracts, or group policyholders of group policies and contracts, 30 days' notice of the termination of the benefits provided pursuant to subdivision (a).

(c) The association shall make available substitute coverage on an individual basis in accordance with the provisions of subdivision (d), to each known insured or an annuitant under nongroup life and health insurance policies and annuities covered by the association, or owner if other than the insured or annuitant, and to each individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, if the insured or annuitant had a right under law or the terminated policy or 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.

(d) In providing the substitute coverage required under subdivision (c), all of the following apply:

(*i*) The association may offer either to reissue the terminated coverage or to issue an alternative policy.

(*ii*) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

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

(e) An alternative policy adopted by the association shall be subject to the approval of the commissioner. The association may adopt an alternative policy for future issuance without regard to any particular impairment or insolvency. An alternative policy shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten. An alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(f) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

(g) The association's obligations with respect to coverage under a policy of the impaired or insolvent insurer or under a reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(7) If proceeding under subsection (3)(b) or (5) for 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 7704(5)(c).

(8) Nonpayment of premiums within 31 days after the date required under the terms of a 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 for a claim incurred or any net cash surrender value which 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 if guaranty protection is also provided to residents of this state by the laws of the domiciliary state of the impaired insurer or insolvent insurer.

(11) In carrying out its duties under this section, the association, subject to approval by a court in this state, may do the following:

(a) Impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter or that the economic or financial

conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens to be in the public interest.

(b) Impose 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, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, 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 insurer or insolvent insurer, the association may defer the payment of the cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, but not for claims covered by the association that are to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(12) A deposit in this state, held pursuant to law or required by the commissioner 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 insurer domiciled in this state or in a reciprocal state, pursuant to section 8153, shall be promptly transferred to the association in accordance with section 8141a. The association may apply a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of all policy owners' claims related to that insolvency for which the association has provided or will provide statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency with the remainder used to pay claims pursuant to section 8141a(1)(a) to (e). Any amount remaining after the payment of claims under section 8141a(1)(a) to (e) shall be transferred to the domiciliary receiver.

(13) If the association fails to act as provided in subsections (3) and (5) within a reasonable period of time, the commissioner shall have the powers and duties of the association under this chapter with respect to impaired insurers or insolvent insurers.

(14) The association may render assistance and advice to the commissioner, upon his or her request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired insurer or insolvent insurer.

(15) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired insurer or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property that the association may have rights to through subrogation or otherwise. The standing shall extend 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 insurer or insolvent insurer and the determination of the covered policies and contractual obligations. The association may also appear or intervene before a court in another state with jurisdiction over an impaired insurer or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

(16) A person receiving benefits under this chapter shall be considered to have assigned the 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 the association of such rights and causes of action by a payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of rights or benefits conferred by this chapter upon that person. The association shall be subrogated to these rights against the assets of an impaired insurer or insolvent insurer. The subrogation rights of the association under this subsection has the same priority against the assets of the impaired insurer 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 insurer or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contract, including without limitation for a structured settlement annuity, any right 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 of the annuity.

(17) If subsection (16) is invalid or ineffective for any person or claim for any reason, the amount payable by the association for the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portions thereof, covered by the association.

(18) If the association has provided benefits for a covered obligation and a person recovers an amount that the association has rights to as described in subsection (16), the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(19) In addition to other rights and powers under this chapter, the association may do the following:

(a) Enter into contracts necessary or proper to carry out the provisions and purposes of this chapter.

(b) Sue or be sued, including taking legal actions necessary or proper for recovery of unpaid assessments levied under section 7709 and to settle claims or potential claims against it.

(c) Borrow money to effect the purposes of this chapter. Notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(d) Employ or retain the people necessary to handle the financial transactions of the association and to perform other functions that become necessary or proper under this chapter.

(e) Negotiate and contract with a liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.

(f) Take legal action necessary to avoid or recover payment of improper claims.

(g) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter.

(h) Join an organization of 1 or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(i) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter to the person, and the person shall promptly comply with the request.

(j) Take other necessary or appropriate action to discharge its duties and obligations and to exercise its powers under this chapter.

(20) At any time within 1 year after the coverage date, the association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to contracts, in whole or in part, by the association, under any 1 or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association; provided, however, that the association shall not exercise this election for a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement on which the association becomes responsible for the obligations of a member insurer. The association shall make an election under this subsection by providing a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurer. If the association makes an election, all of the following apply with respect to the agreements selected by the association:

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

(b) The association is entitled to any amounts payable by the reinsurer under the agreements for losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part, provided that the association is obligated upon receipt of this amount to pay to the beneficiary under the policy or contract on account of which they were paid the amount received by the association that is in excess of the benefits paid by the association on account of the policy or contract less the retention of the impaired member insurer or insolvent member insurer applicable to the loss or event.

(c) Within 30 days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each such reinsurance agreement as of the date of the association's election, which calculation shall give full credit to all items paid by either the member insurer or its receiver, rehabilitator, or liquidator or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or the indemnity reinsurer shall pay the net balance due the other within 5 days of the completion of this calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to subdivision (b), the receiver, rehabilitator, or liquidator shall remit this amount to the association as promptly as practicable.

(d) If, within 60 days of the election, the association pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer shall not terminate the reinsurance agreements insofar as the agreements relate to contracts covered by the association in whole or in part and shall not set off any unpaid premiums due for periods prior to the coverage date against amounts due the association.

(e) As used in this subsection, "coverage date" means the date on which the association becomes responsible for the obligations of the member insurer.

(21) If the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subsection (20) effective on the date agreed to by the association and the other insurer and regardless of whether the association has made the election referred to in subsection (20). If this occurs, the indemnity reinsurance agreement automatically terminates for new

reinsurance unless the indemnity reinsurer and other insurer agree to the contrary and the obligations described in subsection (20)(b) no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer. This subsection does not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in subsection (20).

(22) Subsections (20) and (21) shall be applied consistently with section 8132 and shall supersede the provisions of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator or the insolvent member insurer. The receiver, rehabilitator, or liquidator remain entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date, subject to applicable setoff provisions.

(23) Except as otherwise expressly provided in subsections (20) to (22), this section does not do any of the following:

(a) Alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer.

(b) Abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement.

(c) Give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

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

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

(26) Venue in a suit against the association arising under this chapter shall be in Ingham county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

(27) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsection (3) or (5), the association may, subject to the commissioner's or the receivership court's approval, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value, by issuing an alternative policy or contract in accordance with the following provisions:

(a) Instead of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value.

(b) There is no 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 is substantially similar to the replaced policy or contract in all other material terms.

Sec. 7709. (1) Except as otherwise provided in this section, 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 such time and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after written notice to the member insurers and shall accrue interest at 12% per annum on and after the due date.

(2) There shall be 2 classes of assessments, as follows:

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

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 7708 for an impaired insurer or insolvent insurer.

(3) The amount of a class A assessment shall be determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. The total of all nonpro rata assessments shall not exceed $150.00 per member insurer in 1 calendar year.

(4) The amount of a class B assessment shall 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 insurer or insolvent insurer or any other standard considered by the board in its sole discretion as being fair and reasonable under the circumstances.

(5) A class B assessment against member insurers for each account and subaccount shall 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 3 most recent calendar years for which information is available preceding the year in which the

insurer became impaired or insolvent bears to such premiums received on business in this state for those 3 most recent calendar years by all assessed member insurers.

(6) An assessment for funds to meet the requirements of the association with respect to an impaired insurer or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (2) and computation of assessments under this section shall 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.

(7) 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 that insurer's contractual obligations. If an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. 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.

(8) The total of all assessments authorized by the association for a member insurer for each subaccount of the life insurance and annuity account and for the health account shall 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 account or subaccount during the 3 calendar years preceding the year in which the insurer became an impaired insurer or insolvent insurer, subject to the following:

(a) If 2 or more assessments are authorized in 1 calendar year for insurers that become impaired insurers or insolvent insurers in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation under this subsection are equal and limited to the higher of the 3-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(b) 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 shall be assessed as soon thereafter as permitted by this chapter.

(9) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to 1 or more impaired insurers or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(10) If the maximum assessment for a subaccount of the life insurance and annuity account in any 1 year does not provide an amount sufficient to carry out the responsibilities of the association, then, pursuant to subsection (5), the board shall access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in subsection (8).

(11) The board may refund to member insurers, by an equitable method as established in the plan of operation and 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 future obligations of the association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in an account to provide funds for the continuing expenses of the association and for future claims. Instead of a class A assessment, the board may transfer on an equitable pro rata basis excess amounts from class B accounts to the class A account.

(12) In determining premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, a member insurer may consider the amount reasonably necessary to meet assessment obligations under this chapter.

(13) The association shall issue to an insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution in a form prescribed by the commissioner for the amount of the assessment so paid. All outstanding certificates shall 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 the insurer's financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(14) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as stated in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest. Within 60 days following 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 issues raised by the protest. 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. Instead of rendering a final decision on 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. If the protest or appeal is resolved in the member insurer's favor, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

(15) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with this request.

Sec. 7711. (1) In addition to the duties enumerated elsewhere in this chapter, the commissioner shall:

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

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to that insurer's shareholders, if any. The failure of the insurer to promptly comply with the demand does not excuse the association from the performance of the association's powers and duties under this chapter.

(c) In a liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(2) In addition to the powers enumerated elsewhere in this chapter, the commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on a member insurer that fails to pay an assessment when due. The forfeiture shall not exceed 5% of the unpaid assessment per month, but forfeiture shall not be less than $100.00 per month.

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

(4) The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of this chapter.

Sec. 7712. (1) To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner shall do the following:

(a) Notify the commissioners of all the other states, territories of the United States, and the District of Columbia when he or she takes any of the following actions against a member insurer:

(*i*) Revokes a certificate of authority.

(*ii*) Suspends a certificate of authority.

(*iii*) Makes a formal order that the company restricts its premium writing, obtains additional contributions to surplus, withdraws from the state, reinsures all or a part of its business, or increases capital, surplus, or any other account for the security of policyholders or creditors.

(b) Mail the notice under subdivision (a) to all commissioners within 30 days following the action taken.

(c) Report to the board of directors when he or she has taken any of the actions set forth in subdivision (a) or has received a report from any other commissioner indicating that such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(d) Report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the insurer may be an impaired insurer or insolvent insurer.

(e) Furnish to the board of directors the NAIC 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 may use that information in carrying out its duties and responsibilities under this section.

(f) The report and the information furnished pursuant to this subsection shall be kept confidential by the board of directors until made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning a matter affecting his or her duties and responsibilities regarding the financial condition of a member company seeking to transact insurance business in this state.

(3) The board of directors, upon majority vote, may make reports and recommendations to the commissioner upon a matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the

solvency of a company seeking to transact insurance business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors, upon majority vote, may notify the commissioner of information indicating that a member insurer may be an impaired insurer or insolvent insurer.

(5) The board of directors, upon majority vote, may request that the commissioner order an examination of a member insurer that the board in good faith believes may be an impaired insurer or insolvent insurer. Within 30 days after the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by a person whom the commissioner designates. The cost of the examination shall be paid by the association, and the examination report shall be treated in the same manner as other examination reports. An examination report shall not be released to the board of directors before release to the public, but this does not preclude the commissioner from complying with subsection (1). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but shall not be open to public inspection before release of the examination report to the public.

(6) The board of directors, upon majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(7) At the conclusion of an insurer insolvency in which the association was obligated to pay covered claims, the board of directors shall prepare a report to the commissioner containing information in the board's possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer and may adopt by reference a report prepared by such other associations.

Sec. 7714. (1) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds on an impaired insurer or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out powers and duties under section 7708. Association records concerning an impaired insurer or an insolvent insurer shall not be disclosed before the termination of a liquidation, rehabilitation, or conservation proceeding involving an impaired insurer or insolvent insurer, or before the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to render a report of association activities under section 7715.

(3) For the purpose of carrying out obligations under this chapter, the association shall be considered a creditor of the impaired insurer 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 section 7708(16). Assets of the impaired insurer or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer or insolvent insurer as required by this chapter. As used in this subsection, "assets attributable to covered policies" means that proportion of the assets which the reserves that should have been established for the covered policies bear to the reserves that should have been established for all policies of insurance written by the impaired insurer or insolvent insurer.

(4) As a creditor of an impaired insurer or insolvent insurer as provided in subsection (3) and consistent with chapter 81, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this act. If the liquidator has not, within 120 days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled 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 assets.

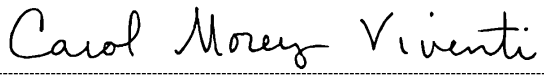
Sec. 7717. There is no liability on the part of and a cause of action does not arise against a member insurer or an insurer's agents or employees, the association or the association's agents or employees, members of the board of directors, or the commissioner or his or her representatives for any action or omission by them in the performance of powers and duties under this act. This immunity shall extend to the participation in an organization of 1 or more other state associations of similar purposes and to the organization and its agents or employees.

Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred.

(2) Section 838a of the insurance code of 1956, 1956 PA 218, MCL 500.838a, as added by this amendatory act, applies on and after January 1, 2007.

This act is ordered to take immediate effect.

Clerk of the House of Representatives



Secretary of the Senate

Approved _____

_____

Governor