STATE OF MAINE
114TH LEGISLATURE
SECOND REGULAR SESSION

Final Report
of the

SUBCOMMITTEE TO STUDY THE CURRENT OPERATION OF INSURANCE GUARANTY FUNDS

to the
Joint Standing Committee on
Banking & Insurance
December 1989

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I. INTRODUCTION

On March 23, 1989, the Joint Standing Committee on Banking & Insurance held a public hearing on Legislative Document 750 (LD 750), An Act to Amend the Laws Relating to the Maine Insurance Guaranty Association and the Maine Self-Insurance Guarantee Association. The bill proposed major changes in the statutes governing the insurer organizations that take over the responsibilities of insolvent insurance companies. Although proponents intended to have the bill considered in time to avert an emergency, the insolvency of a major New England insurer in early March created an emergency and hastened the need for committee action on the proposal.

The committee held several work sessions on LD 750 during the month of April, and decided on April 26th to recommend passage of LD 750 in amended form.

As part of the compromise agreement on LD 750, the bill included a repeal of some major provisions 91 days after adjournment of the Second Regular Session of the 114th Legislature. The repeal was coupled with a requirement that the Banking & Insurance Committee study the issue of guaranty funds during the interim between the First and Second Regular Sessions. LD 750 passed both houses of the Legislature on April 27th and was signed into law by the governor on the same day as 1989 Public Law, Chapter 67.

After receiving staff and funding approval from the Legislative Council, the chairs of the Banking & Insurance Committee appointed a 5-member "Subcommittee to Study the Current Operation of State Insurance Guaranty Funds." The following report and proposed legislation are the result of that subcommittee study.

II. EXECUTIVE SUMMARY & SUMMARY OF RECOMMENDATIONS

A. Executive Summary

Guaranty associations are important consumer protection devices: they ensure that the obligations of insurers to cover the losses of their policyholders will be fulfilled, even if the insurer that issued the policy becomes insolvent. Since 1984, the number and size of insurers writing certain kinds of insurance has increased dramatically. As the number and size of insurer insolvencies increases, the burden on guaranty associations to cover the costs of the insolvencies increases, as does the importance of the function performed by the guaranty associations. Assuring the viability of Maine's guaranty associations is therefore a matter of extreme interest to the subcommittee.

After taking some time to gain perspective on the history of guaranty associations and to examine how Maine's experience with guaranty associations compares with that of other states, the subcommittee turned its efforts to examining ways to strengthen the capacity of Maine's guaranty associations.

The ability of a guaranty association to meet its obligations to policyholders is referred to as its capacity. The capacity of a guaranty association is a function of two factors: liabilities (what types of claims are covered, what are the limits on coverage, how many insurers become insolvent) and assessment base (who is assessed to cover the costs, how much money can be raised through assessments, and what are the implications of the assessment). The subcommittee examined both factors.

In examining ways to decrease liability, the subcommittee compared the coverage provided by Maine statute to that suggested by the model guaranty association acts of the National Association of Insurance Commissioners (NAIC). Those provisions of the NAIC Models that the subcommittee considered appropriate for Maine were recommended for adoption, and are described below.

The question of who should be assessed to fund the guaranty associations was a more difficult and broad-reaching question. During the legislative session, the committee had recommended an expansion of the assessment base by requiring all members insurers of each association to share in the costs of an insolvency when the assessment of insurers writing the same type of insurance as the insolvent insurer was not sufficient to cover the costs of the insolvency. This provision is scheduled to be repealed in the summer of 1990. The majority

of the subcommittee believes that it is necessary to remove the sunset on the "spillover" assessment in order to assure viability of the guaranty association beyond 1990.

At the final meeting of the subcommittee, this issue was strongly debated. One member of the subcommittee disagreed with the final decision of the subcommittee, but did not choose to sponsor a minority report.

The subcommittee also examined ways to improve the oversight of insurers, to minimize the number of insolvencies that affect the guaranty association. Only one insurer domiciled in Maine (a "domestic insurer") has become insolvent in the last 20 years, so Maine's regulation of insurers is not viewed as the cause of the problem for Maine's guaranty associations. Although the Maine Bureau of Insurance has authority to examine insurers domiciled outside the state ("foreign" insurers), limited resources and time do not permit full examination of every insurer writing policies in Maine. In Maine, as in most states, the regulation of foreign insurers is left to the regulator of the insurer's state of domicile. The subcommittee therefore did not recommend major changes in the oversight of Maine insurers.

At the request of the subcommittee, however, the Bureau of Insurance submitted five suggestions for additions or amendments to the Insurance Code, which may improve insurer oversight. Within the time limits of the study, the subcommittee was not able to fully examine and analyze these proposals. They are included in the recommendations and will be subject to further study to determine whether they would be effective tools for insurer oversight. The subcommittee believes that improving oversight of insurers to prevent insolvencies and the need for guaranty association coverage is the best way to improve the viability of Maine's guaranty associations.

B. Summary of Recommendations

The subcommittee recommends that the following changes be made in coverage and assessments by the Maine Insurance Guaranty Association (MIGA) and the Maine Life and Health Insurance Guaranty Association (MLHGA):

Changes to the MIGA

Recommendation #1. Exclude coverage of the claims of affiliates of insolvent insurers. Affiliates are in a position to know the condition of the company that becomes insolvent. Also, it is possible that the affiliate may "raid" the insurer's assets and then make a claim against the guaranty fund.

Recommendation #2. Provide for a $50 deductible on claims for unearned premium. A $50 deductible on unearned premium claims would save administrative costs for the association, but would not place an unreasonable burden on policyholders.

Recommendation #3. Exclude coverage of punitive damages. Punitive damages are designed to punish persons who maliciously injure others. Those persons should pay the damages, not the policyholders of solvent insurers.

*** Recommendation #4. Remove the sunset on the spillover assessment.** The majority of the subcommittee believes that a 2% assessment in the separate accounts of the MIGA may not be sufficient in one or more years after 1990, that 2% is the most reasonable limit on assessments in any account in one year, and that it is therefore necessary to continue the "spillover" assessment.

Recommendation #5. Include coverage of marine "protection and indemnity" insurance. Marine protection and indemnity is liability insurance for ocean-going vessels. This should be covered like any other liability. The current statute excludes this coverage, which was not intended by proponents of the 1987 legislation that amended the statute.

Changes to the MLHGA

Recommendation #6. Exclude coverage of a portion of the interest guaranteed by a covered contract when the guaranteed rate exceeds a certain earnings index. An insurer may sell life insurance or annuity contracts under which it guarantees that the policyholder will earn a certain rate of interest on its contributions. In certain instances, the insurer has guaranteed an unrealistic interest rate, which may be a contributing factor or even the cause of the insolvency. It is not fair to require solvent insurers to make good on those unrealistic promises.

Recommendation #7. Exclude coverage of nonresidents when a domestic insurer becomes insolvent, except when the insurer was never licensed in the nonresident's state, that state has a guaranty fund but the fund does not cover the nonresident. This residents-only approach spreads the effect of an insolvency among many states, rather than placing the entire burden of an insolvency on any single state. This helps assure that capacity to handle an insolvency will be sufficient in most if not all events.

*** Recommendation #8. Remove the sunset on the spillover assessment.** Although the MLHGA has not been required to cover the costs of any major insolvencies of life, health or annuity insurers, it is not possible to exclude the possibility that the MLHGA will be required to provide funds to cover a major insolvency, and that the current 2% limit may not be sufficient to cover all likely assessments.

Other Guaranty Association Recommendations

Recommendation #9. Require the Banking & Insurance Committee to examine the guaranty fund statutes in 1993.

Recommendation #10. Require the MIGA and MLHGA to report spillover assessments and annual total assessments. It is essential for the Legislature to be informed of the activities of the Guaranty Associations, especially with respect to the spillover assessments. For this reason, the subcommittee proposes that the MIGA and MLHGA notify the legislative committee with jurisdiction over insurance matters immediately of a vote to impose a spillover assessment. The associations would also be required to report annually to the committee on the total assessments made during the year.

Insurer Oversight Changes

The subcommittee recommends the following amendments and additions to the Insurance Code to improve oversight of insurers:

Recommendation #11: Require insurers to participate in the NAIC Insurance Regulatory Information System (IRIS). IRIS assists insurance regulators in overseeing the financial condition of insurers. Although Maine insurers currently provide the necessary information to the NAIC, there is no statutory requirement that they do so. The subcommittee recommends that this requirement be added to Maine law.

Recommendation #12: Permit the Superintendent of Insurance to have access to the work papers prepared by Certified Public Accountants (CPAs) while auditing insurers. Although Maine law requires insurers to be audited annually by a CPA, and to submit an audited financial statement, it does not require insurers to grant the Bureau of Insurance access to the working papers used in putting together the financial statement. The Bureau believes that the information in the working papers would permit them to oversee the financial condition of the insurer more fully without having to perform a full Bureau examination.

Recommendation #13. Strengthen Maine's law regarding credit for reinsurance. Maine statute currently permits an insurer to receive credit for reinsurance only if the reinsurance is ceded to an assuming insurer that meets certain qualifications. The proposal before the subcommittee would amend the current statute to strengthen it.

Recommendation #14. Limit investments in "Junk Bonds" by property/casualty insurers. Current Maine law limits investments in "junk bonds" by life insurers, but does not distinguish between junk bonds and other less risky corporate obligations for non-life insurers. The proposal would limit

investment in obligations which are not ranked in one of the top four rating categories by an independent nationally recognized rating agency, such as Moody's or Standard & Poor's, and which do not have an average annual yield of maturity more than 300 basis points higher than an issue of comparable maturity issued by the United States.

Recommendation #15. Require Third Party Administrators of health and other benefit insurance plans to be regulated by statute and licensed by the Bureau of Insurance. Third Party Administrators (TPAs) act as service providers to insureds on behalf of insurance companies. They collect premiums, and process and pay claims pursuant to the terms of a contract with the insurer and under the terms of the insurance policy. The subcommittee recommends that TPAs be regulated by the state Bureau of Insurance. Regulation would include requirements that the TPA be licensed and bonded, maintain fiduciary accounts for clients, and make certain reports to their clients.

* Senator Beverly Bustin does not concur in subcommittee recommendations #4 and #8. Senator Bustin's reasons for non-concurrence are stated in Section IV (B) (3) of the report.

III. BACKGROUND

A. What are Guaranty Associations?

Guaranty associations are organizations composed of all the companies writing certain kinds of insurance in the state. The purpose of a guaranty association is to assume the responsibilities of insurance companies that become insolvent.[1] Assuming responsibility generally means paying the claims of policyholders of the insolvent insurers. In some cases, it also means arranging for other insurance companies to continue insurance coverage of the policyholders of the insolvent insurer. Guaranty associations raise funds to perform these functions through assessments of their member insurers.

In almost all states, insurers writing property or casualty insurance[2] belong to a guaranty association which is separate from the association of insurers writing life, health or annuity contracts or policies. Every insurer that writes a line of insurance covered by a guaranty association must be a "member" of the guaranty association as a condition of maintaining its certificate of authority, or license, to write that insurance in the state. Only insolvencies of "member insurers" are covered by the guaranty association.

When an insurer is declared insolvent, the guaranty association in each state in which the insurer wrote business determines what amount it is likely to need in order to pay for losses, expenses, and unearned premium[3] due to the insolvent insurer's policyholders who reside in that state, and how much will be needed to pay for administration of the association.[4] The guaranty association then assesses its members for the amount needed to meet its obligations.[5] In many states, the association is split into two or more "accounts." Insurers writing a similar type of insurance are participants in the "account." For example, all auto insurers participate in the auto account, and when an auto insurer becomes insolvent, the auto account members bear the cost. In other states, there is only one "account" and all property/casualty insurers or all life/health/annuity writers share the cost of insolvencies. The assessments within the accounts are based on the amount of premium written by a member insurer in that line of business and is limited, usually to 2% of the insurer's premium used for assessment.[6] Member insurers may receive partial refunds of assessments if the guaranty association is able to recover funds during the liquidation of the insolvent insurer. This may occur many years after payment of the assessment.

Life/health associations operate somewhat differently. Their main function is to assure continued insurance coverage for the policyholders of insolvent insurers, rather than to pay claims. Since health and life contracts are designed to be long-term arrangements, and since the ability of a policyholder to obtain similar insurance at comparable rates may diminish over time, the payment of claims alone does not provide sufficient assistance to policyholders. The association therefore is authorized to guarantee, assume or reinsure (arrange for another company to assume coverage) the policies. The association is also authorized to assist "impaired" insurers, to attempt to prevent insolvency.

State statutes determine the extent of the guaranty fund obligations and the limits and exclusions of coverage for the policyholders in that state. For example, the statute may set a $100 deductible on claims for unearned premium, or may exclude them altogether.

B. History

Except for enactment of New York's guaranty fund law in 1941, guaranty associations did not exist until the early 1970's. Prior to passage of guaranty fund laws, persons whose insurance companies failed had no recourse for their losses, unless they were able to recover when the insurer was liquidated. The guaranty fund acts were the first attempt to provide reinforcement for the obligations of insurance contracts and to reassure policyholders that they would be reimbursed for losses.

Most guaranty association statutes are based on model legislation developed by the National Association of Insurance Commissioners (NAIC). The drafting of the NAIC Model Acts was a response to pressure from Congress throughout the 1960's for a federal solution to the issue of insurer insolvency.[7] The theory behind the property/casualty model act was to provide coverage to the individual insured who was unable to avoid losses by choosing knowledgeably among insurers and was unable to bear the loss without undue difficulty. Commercial insureds were presumed to have access to advisors and information to enable them to steer clear of shaky insurers, as well as the resources to absorb the losses if their insurers failed. Consistent with the theory, the model act provided caps and deductibles based on an individual's likely loss, and an individual's ability to afford a deductible. Limitations on recovery that would affect commercial insureds were designed to provide incentive for those insureds to choose wisely.

All states but New York and Wisconsin have adopted some variation of the NAIC Model Property/Casualty Act. Forty-four states have life/health guaranty associations. The NAIC has reexamined its Model Acts several times, in response to the changing nature and size of insurer insolvencies.

C. Maine's Guaranty Associations

Maine law establishes three guaranty associations: the Maine Insurance Guaranty Association (MIGA)[8], the Maine Life and Health Insurance Guaranty Association (MLHGA)[9], and the Maine Self-Insurance Guarantee Association (MSIGA)[10].

All insurers authorized to write property or casualty insurance in Maine, except those property/casualty lines specifically excluded by the statute, must be members of the MIGA. The MIGA is separated into three "accounts:" the auto insurance account; the workers' compensation account; and the "all other" account. Participants in each account are primarily responsible for paying the claims of insurers writing that type of insurance. For example, all workers compensation insurers are participants in the workers' compensation account. When an insurer writing workers' compensation insurance is declared insolvent, workers compensation insurers are assessed to cover those policies. Prior to passage of Legislative Document 750 (LD 750, 1989 Public Law Chapter 67), only the members of each account were assessed to pay the claims of that type of insurance. As a result of LD 750, insurers in the account are primarily responsible for paying claims. (See Section F for an explanation of LD 750) If funds are needed beyond the 2% limit set for that account, insurers in the other accounts are assessed to pay for the claims. This assessment has been referred to as the "spillover assessment." There is a "circuit breaker" on the spillover assessment which limits the percent of an insurer's net income which must be paid as an assessment for the spillover. The circuit breaker is designed to prevent financial difficulties in smaller insurers that have less ability to bear the burden of the assessment. Both the spillover assessment and the circuit breaker are scheduled for repeal 91 days after adjournment of the Second Regular Session of the 114th Legislature.[11] LD 750 also added a requirement that the guaranty association maintain a line of credit with a qualified financial institution, so that funds will be immediately available in the event of an insolvency.

The MIGA is run by a Board of Directors, composed of representatives of member insurers who are elected by the member insurers, subject to approval of the superintendent of insurance. The association's activities are administered by Guaranty Fund Management Services, a Massachusetts-based company which administers guaranty funds for the six New England states, the state of Virginia, and the District of Columbia.

All insurers authorized to write life, health or annuity policies or contracts in the state must be members of the MLHGA. The MLHGA is also separated into three accounts: the life insurance account, the health insurance account, and the annuity account. As in the MIGA, the accounts are primarily

responsible for insurer insolvencies in those accounts, and may be assessed up to 2% of their premiums. As a result of LD 750, the other accounts are liable for a "spillover assessment." In the MLHGA there is no circuit breaker mechanism for the spillover assessment. The MLHGA also must maintain a line of credit for immediate funds.

The MLHGA is also run by a Board of Directors composed of elected member insurers. In contrast to the MIGA, the MLHGA has not been required to perform significant activities to date, and has not therefore arranged for a full-time administrator for the fund.

The MSIGA is composed of all employers in the State that self-insure for workers' compensation. The MSIGA is affected by one of the changes made by Legislative Document 750, and the discussion of LD 750 in section F does refer to the MSIGA. Except for that section, however, this report does not discuss the MSIGA, since no changes to the structure or functions of the MSIGA were recommended or discussed during the study.

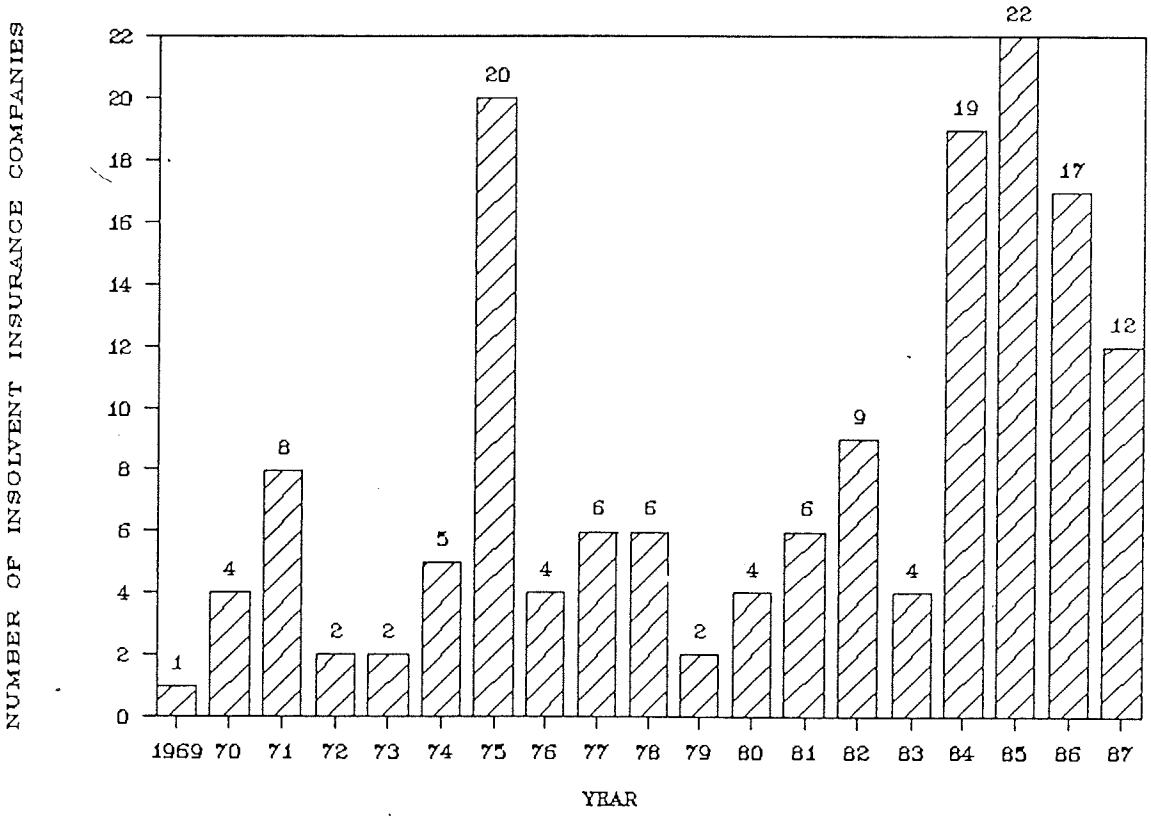
D. Why are Guaranty Associations an Issue?

Guaranty associations, in particular the property/casualty associations, became an important issue nationwide in the last two or three years, as the number and size of insurer insolvencies increased dramatically. When guaranty associations were formed in the early 1970's, they were covering the insolvencies of small local or regional insurers, generally those writing personal lines of insurance such as auto insurance for "high-risk" drivers.[12] Since 1983, however, the size and nature of insurer insolvencies has changed dramatically.

1. Property/Casualty Insurers

Between 1969 and 1983, 83 property/casualty insurers around the country became insolvent, or an average of about 6 companies a year. Between 1984 and 1987, a total of 69 companies were declared insolvent, or an average of 16 per year.[13]

Figure 1. Property/Casualty Insurer Insolvencies

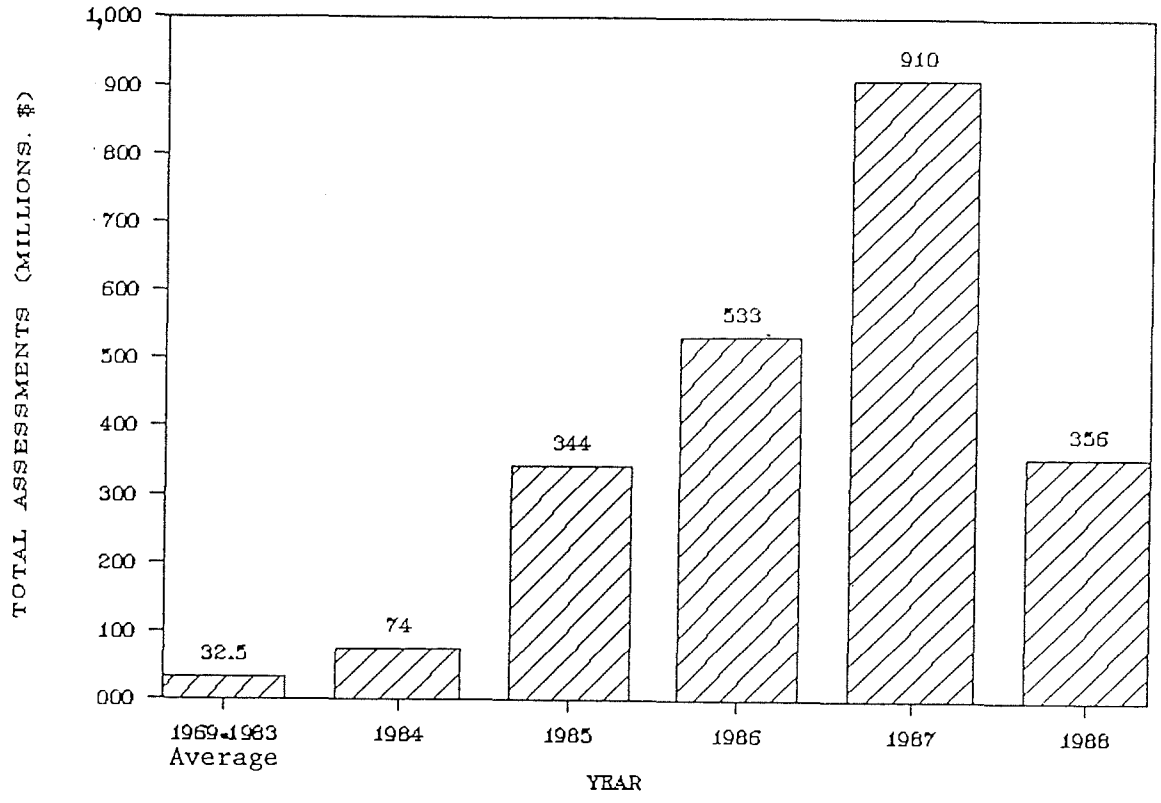


Source: National Committee on Insurance Guaranty Funds

The size of companies becoming insolvent has increased, as has the frequency of insolvencies. Prior to 1984, the largest insolvency assessment for a company was made for the insolvency of the Reserve Insurance Company in 1979, resulting in about $85 million in assessments nationwide. The 1985 insolvency of Ideal Mutual Insurance Company was almost three times as large, resulting in almost $240 million of assessments. In that same year, the Transit Casualty Company insolvency caused $260 million of assessments. The Ideal Mutual and Transit Casualty insolvencies alone exceeded the total assessments for all insolvencies between 1969 and 1983. The 1987 insolvencies of the Mission Insurance Company and the Mission National Insurance Company have already resulted in $370 million in assessments, and will probably require additional assesments.[14]

The total assessment in one year against member insurers for all insolvencies has also increased dramatically. From 1969-1983, property casualty guaranty funds assessed a total of $452.4 million, or an average of about $32.5 million per year. In 1986 alone, insurers paid more than in all years from 1969 to 1983, a total of $530 million. And in 1987, almost $1 billion was assessed to pay the costs of insurer insolvencies.[15]

Figure 2. Assessments by Guaranty Associations, Nationwide

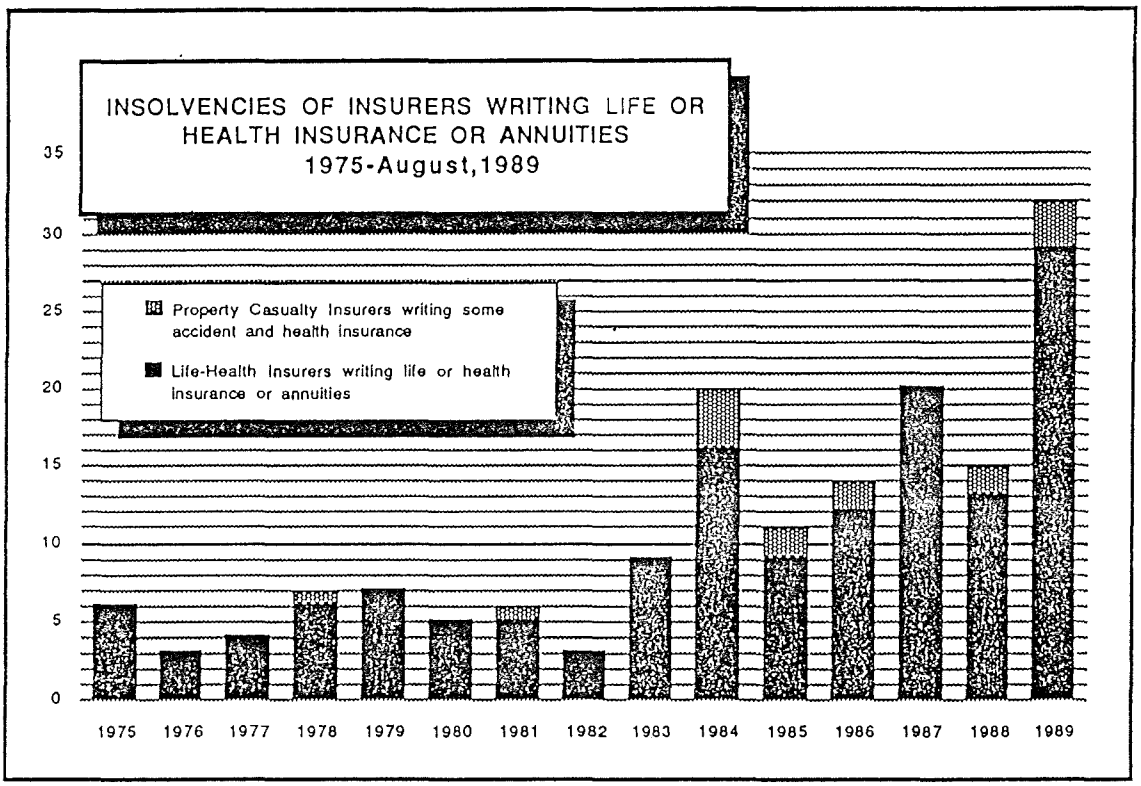


Source: National Committee on Insurance Guaranty Funds

2. Life/Health Insurer Insolvencies

Less attention has been paid to associations that back life and health insurers. Although the number of insolvent companies has equalled that of insolvent property/casualty insurers in some years, the comparatively small size of the insolvent life and health insurance companies has resulted in a lesser burden than that imposed on the property/casualty associations. Turmoil in the industry, however, particularly the health insurance industry, causes some experts to predict that the size and frequency of life/health insurer failures may increase. Eden Sarfaty, Executive Director of the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) cautioned the subcommittee that increasing health insurance costs and utilization, increasing competition among insurers and AIDs claims may cause turmoil in the industry and therefore in life/health guaranty associations.

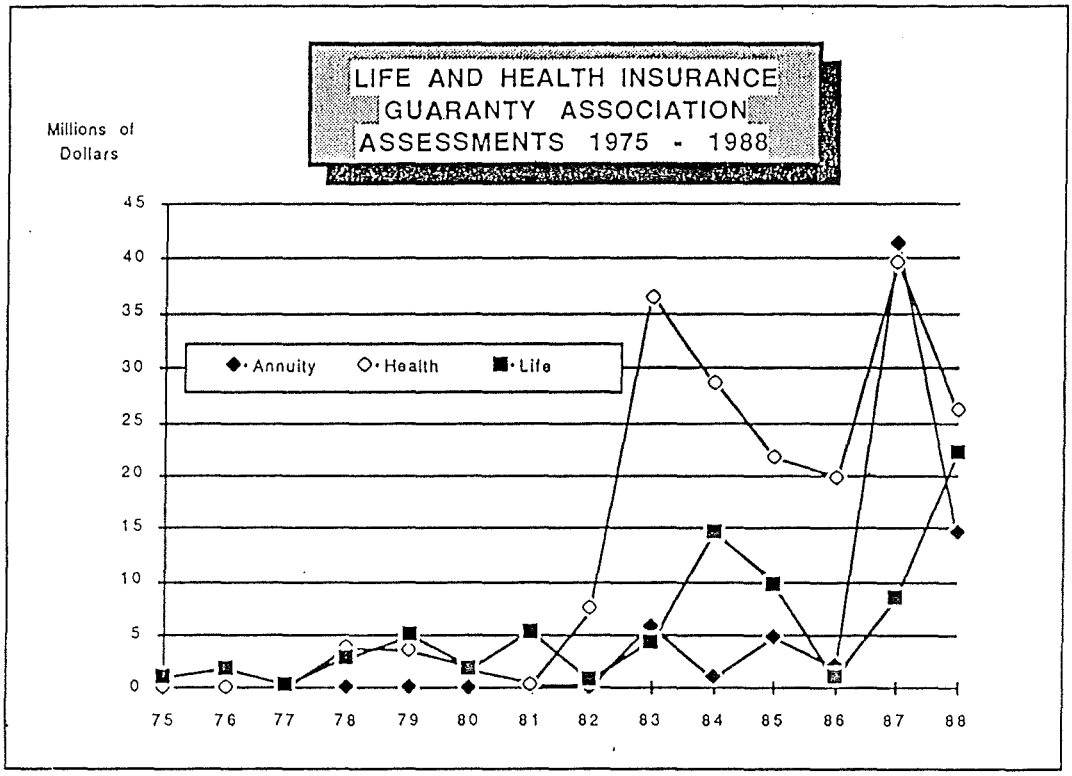
Figure 3. Insolvencies of Life/Health Insurers



Source: National Organization of Life and Health Insurance Guaranty Associations

To date, assessments by life/health guaranty associations from 1975-1988 have totalled about $340 million.[16] This compares to a 1969-1988 assessment total of almost $2.5 billion by property/casualty associations.[17]

Figure 4. Total Assessments by Life/Health Guaranty Associations, Nationwide



Source: National Organization of Life and Health Insurance Guaranty Associations

Other than the 1983 insolvency of the Baldwin-United[18] Insurance Company, insolvencies of individual life/health companies have not attracted the attention that insolvencies like the Mission insolvency have attracted among property/casualty insurers. The authority to assess up to 2% of premium has been sufficient to meet the needs of life/health guaranty associations, and no individual insolvency or yearly total of assessments has strained the capacity of the life/health funds to date.

E. The Scope of the Problem in Maine

1. The Maine Insurance Guaranty Association

Tracking the national experience, the MIGA did not make substantial or frequent assessments prior to 1984. The largest assessment was made in 1979 for the insolvency of the Reserve Insurance Company, a total of about $200,000: $150,000 in the All Other Account, $50,000 in the Auto Account.

In 1984, however, the Ambassador Insurance Company insolvency necessitated assessments of close to $1.5 million: almost $600,000 in the Auto Account and almost $900,000 in the All Other Account. Beginning in 1986, the assessments were not only larger than ever before, but occurred every year and for a larger number of insolvencies. In 1987, assessments were required for failures of 12 property/casualty insurers.[19]

The insolvencies that caused national attention and problems also hit Maine hard. The insolvency of Ideal Mutual Insurance Company in 1985 resulted in assessments of $1.7 million, assessed over a period of three years from 1985 to 1988. The Transit Casualty Company insolvency caused a total of $1.2 million of assessments in Maine between 1986 and 1988. The 1987 insolvency of the Mission Insurance Company, a writer of excess coverage of workers' compensation insurers in Maine[20], not only resulted in large assessments, but adding to the burden of several other workers compensation insolvencies, resulted in a crisis in the spring of 1989. The number of policies written in Maine was small,[21] but the total expected obligation of the MIGA for Mission was not.

Prior to 1989, the MIGA assessment authority was limited to 1% of premium written in Maine, although the limit nationally was generally 2%. In 1988 the MIGA assessed the maximum 1% of premium of all workers' compensation insurers in the state, to pay for the Mission Insurance Company insolvency. When that assessment was insufficient, the MIGA borrowed $2.5 million from the Workers' Compensation Pool Board in New York City. That loan was originally due for repayment on March 1, 1989.

In February 1989, workers' compensation insurers were again assessed the full 1% of premium. By March it was clear that this amount would not be sufficient to cover claims for the year, much less to repay the $2.5 million loan from 1988. As LD 750 was being prepared for consideration in the Legislature, another company writing workers' compensation in the state, American Mutual Insurance Company, was declared insolvent, adding further burden and urgency to the workers' compensation account.

2. Maine Life and Health Insurance Guaranty Association

In contrast, the MLHGA had not before 1988 made any assessments for insolvencies of life, health or annuity writers in the state. A small start-up administrative assessment was made in 1984. The only other assessment of which the Legislature was aware in 1989 was a planned assessment of approximately $100,000 to cover long-term disability contracts written by the American Mutual Insurance Company.

F. Legislative Action in the 1989 Session

In March of 1989, LD 750 was referred to the Joint Standing Committee on Banking & Insurance. The original proposal, developed by the Bureau of Insurance, was designed to:

1. Provide sufficient capacity in the MIGA and the MLHGA by increasing the assessment limit in the MIGA from 1% of premium to 2% of premium; and by providing for sharing of the burden of assessments among all three accounts in each association after the responsible account had been assessed its full 2% of premium. Under this mechanism, the amount available for the insolvency of any one type of insurer would be 4% of premium from the responsible account, and up to 2% of premium from the other two accounts.

2. Assure immediate access to funds upon an insolvency by requiring a "pre-assessment" fund in each association. Insurers would be subject to assessment of up to 1/2 of 1% each year, regardless of whether the funds were immediately needed to pay for an insolvency. This assessment would allow a build-up of funds so that money would be available immediately upon an insolvency, without having to wait the 60 days or so that an assessment procedure may require;

3. Place the responsibility for excess workers' compensation coverage on self-insurers who purchase that coverage by shifting the responsibility of that coverage from the MIGA to the Maine Self-Insurance Guarantee Association (MSIGA); and

4. Assure that insurers who are member insurers of an association on the date of an insolvency, but who withdraw from Maine before the claims resulting from that insolvency are all paid, will remain subject to assessment to pay those claims. This would eliminate the incentive for insurers to leave the state to avoid paying for insolvencies, and would assure a broader base of premiums on which to make assessments.

During committee hearings and work sessions on the bill, insurance industry representatives strongly opposed the pre-assessment fund, and one insurance trade organization, the National Association of Independent Insurers, also strongly opposed the concept of a "spillover" or "superfund" assessment.

The alternative proposed to the pre-assessment fund was the maintenance of a line of credit by each Association, in an amount estimated to be sufficient to pay claims for the first 60 days after an insolvency. If the Association is unable to obtain the line of credit, individual member insurers would be required to obtain lines of credit, payable on one day's notice to the Association. If no lines of credit were obtained, the member insurers would be subject to a pre-assessment.

Opposition to the three-account assessment resulted in a change in that procedure, which was designed to assure an adequate assessment base. Instead of having all three accounts share in the assessment after any one account was assessed a full 2%, the amended proposal would subject only the two accounts not responsible for the insolvency to the "spillover" assessment. So the maximum assessment on any account in one year would be 2%, rather than a possible 4% assessment on the responsible account, and 2% on the others. A proposal to assure that the spillover assessments did not have an adverse effect on smaller member insurers was also added. The "circuit breaker" provides that small insurers will not have to pay more than 5% of their three-year average net income as a spillover assessment. A small insurer is one with less than $12 million of surplus, and either net income less than $250,000 or a premium to surplus ratio greater than 2:1 in the year prior to the assessment.

The proposal to move coverage from the MIGA to the MSIGA for workers' compensation self-insurer excess was altered also. Instead of requiring the MSIGA to be liable immediately on the insolvency of an excess writer, the self-insuring employer would be liable to make payments first. Only if the employer was unable to make payments would the MSIGA be responsible for paying injured worker benefits.

The proposal to assure assessment of withdrawing employers was not changed. An additional provision was added to assure that writers of workers' compensation excess insurance would remain liable for claims resulting from those policies even after the policies cease being covered by the MIGA, whether or not the insurer withdraws from the state.

LD 750 represented a major change in the structure of the guaranty associations. As it concluded consideration of LD 750, the committee felt that while it supported making the immediate changes in the associations, the issue of guaranty associations required further study. Therefore, LD 750 included a provision for the Committee to study the issue as a basis for making any further legislative changes.

IV. THE STUDY: EXPLORING WAYS TO IMPROVE MAINE'S INSURANCE GUARANTY ASSOCIATIONS

After hearing background on the history of guaranty associations, and the operations of the MIGA and the MLHGA, the subcommittee turned its attention to examining ways to improve Maine's guaranty association statutes. Since the charge to the associations is to assure adequate capacity, the subcommittee looked at ways to increase capacity by decreasing the liability of the associations or by increasing the assessment base of the associations.

The subcommittee also explored ways to prevent Maine insurers from becoming insolvent, by changing regulatory practices or urging better use of information available to purchasers and agents of insurance to avoid placing business with weak insurers.

At the invitation of the subcommittee, the following people provided information during subcommittee meetings, presenting information and opinions, and responding to subcommittee questions on these issues:

- Paul M. Gulko, President
  Guaranty Fund Management Services
- Eden Sarfaty, Executive Director
  National Organization of Life and Health Insurance Guaranty Associations (NOLHGA)
- David J. Brummond, Asst. Vice President and Asst. General Counsel, National Association of Independent Insurers (NAII)
- Superintendent Joseph A. Edwards, and
  Deputy Superintendent Everard B. Stevens,
  Maine Bureau of Insurance
- Judy Plummer, Director of Governmental Affairs,
  Independent Insurance Agents of America
  Maine Chapter (IIAAM)
- Wanda Gagnon, Professional Insurance Agents (PIA)

Numerous representatives of the insurance industry also attended the subcommittee meetings and provided responses and information to the subcommittee during the course of meetings.

A. The Capacity of a Guaranty Association

The ability of a guaranty association to meet its obligations to policyholders is referred to as its "capacity." The subcommittee was primarily concerned with assuring that the MIGA and the MLHGA have adequate capacity for the future.

The capacity of a guaranty association is a function of:

- the "exposure" of the association -- how many people it covers, what types of insurance it covers, the size, number and frequency of insolvencies, and the payout pattern of an insolvency (whether payments are large and immediate, or smaller and spread over a long period of time);

- the assessment base of the association -- who is assessed to pay the costs; the size of the assessment base, and how widely the assessment is spread; and

- the timing of the exposure.

Some of these factors are controlled by legislation, for example, the lines of insurance covered by the association; many, however, are factors over which the Legislature has little or no control, such as the number and frequency of insolvencies, and the payout pattern of a particular insolvency. Although the subcommittee received comments and judgments about the likely number and frequency of future insolvencies, members recognized that it is impossible to predict the exact future needs of the association, or where the greatest burden on the association will occur. There is therefore no "right" or "wrong" way to structure a guaranty association statute. The subcommittee therefore undertook to make reasonable choices about the coverage of the associations and assessment practices, balancing the desire to protect policyholders of insolvent insurers against the recognition that solvent insurers and their policyholders are required to pay the costs of that protection.

B. The Capacity of the MIGA

1. Exposure

The subcommittee examined possible changes to the coverage of the MIGA by comparing the Maine statute with the NAIC Model Property/Casualty Guaranty Association Act. The subcommittee reviewed each of the differences and decided whether the rationale of the NAIC and other supporters of the changes merited adoption in Maine. Those decisions and the rationales are discussed more fully in the list of recommendations.

In deciding what types of insurance to cover, what types of claims to cover, and what limits to impose, the subcommittee took the following considerations as guidelines:

- The guaranty associations should cover those insureds and claimants who do not have the knowledge or ability to determine the strength of an insurer and therefore to choose wisely. This consideration caused the subcommittee to be cautious in removing coverage for lines of insurance that cover individuals or small businesses in Maine.

- The guaranty associations should cover claimants who are not financially able to bear the loss, again the individual and small businesses.

- The subcommittee's desire to provide as much protection as possible to Maine policyholders must be tempered with the realization that Maine policyholders also bear the cost of that protection.

2. Timing

Regardless of the size of the losses covered by a guaranty association, an important factor in determining the ability of the association to meet its obligations is the "payout pattern" of the losses: when payments begin and what period they are spread over. The more immediate the need to pay, the more difficult it is to assure adequate capacity. For example, the association must generally begin making workers' compensation payments immediately after an insolvency, so the association must have funds on hand immediately. A medical malpractice claim, on the other hand, may not be payable until after several years of litigation. On the other hand, a workers' compensation claim is often paid over several years, rather than requiring a large lump sum payment. For this reason, a guaranty association may not need to have funds on hand immediately to pay all the workers' compensation claims that will become payable. Uncertainties about the payout pattern of a particular insolvency make it difficult for a guaranty association to know its exposure immediately after an insolvency.

If an insolvency requires large, immediate payments, a guaranty association may be able to spread exposure over one or more years by borrowing funds from a bank or from other accounts in the association. This is not uncommon among guaranty funds. The MIGA borrowed $2.5 million in 1988 in order to make workers' compensation payments. Unfortunately, this was only a temporary solution, since the Association's liability for new claims in the year of repayment exceeded its assessment authority, without allowing for repayment of the 1988 loan.

A second timing issue is the frequency of insolvencies. If insolvencies are spread evenly over the years, a 2% assessment on the affected line of insurance may work. If insolvencies are bunched, as they have been in 1987, 1988 and 1989, a 2% assessment on the affected line may not be sufficient and borrowing to get over one bad year may not be a solution.

The frequency of insolvencies and the payout pattern of insolvencies are not factors over which the Legislature has control, and are not, therefore, topics of recommendations by the subcommittee. However, an understanding of timing issues provided general background to the subcommittee.

3. Assessment Base

Who Pays Now?

Since 1969, property/casualty guaranty associations have been funded by assessments of member insurers. But while insurers initially bear the cost of the funds in all states, they are permitted to pass the cost on to others. In some states, including Maine, insurers are authorized to recover assessments from policyholders through the rates charged for policies issued after the assessment. Policyholders therefore bear most of the burden. In other states, state taxpayers bear all or most of the ultimate burden because insurers are authorized to use assessments to offset their liability for premium or income taxes owed the state.

In all events, insurers bear some of the cost because they pay the assessments and must generally wait for some period of time before recovering the assessment in their rates or through a tax offset. Some insurers also voluntarily absorb some of the cost rather than passing the assessment through their rates, in order to keep rates at a competitive level.

The recognition that insurers bear some of the cost and in states like Maine that policyholders bear the ultimate cost make the issue of which insurers should be assessed for an insolvency important. In 35 states, including Maine until 1989, only those insurers writing the same kind of insurance as the insolvent insurer were assessed to pay claims. In 15 states, all property/casualty insurers pay for the insolvency of any property/casualty insurer, regardless of whether the insurer wrote workers' compensation or auto insurance.

Who Should Pay?

Opinions about who should pay are affected somewhat by how much must be paid. In 1969, the insurance industry accepted responsibility for paying for insolvencies. But at that time, the costs were relatively low. The increased frequency and size of the assessments has caused many in the industry to urge wider spreading of the ultimate burden by permitting a premium

or income tax offset. And although many argue against "merging the accounts" in a guaranty association, that is, assessing accounts other than the one involving the line of insurance written by the insolvent insurer, they also recognize that this may be necessary in states where single accounts do not provide enough capacity.

The question of which line of insurance should pay for an insolvency was one of the major issues of the discussions on LD 750 during the legislative session. The spillover assessment provision of LD 750 spreads the cost of an insolvency beyond the line of insurance in which the insolvency occurred. As a result of the pending repeal of the spillover assessment in 1990, the issue of which insurers should pay remained an issue during the study.

Opponents of the spillover assessment argue that the cost of insolvencies in a line is a cost of that type of insurance and that it is not fair to force writers of different lines of insurance to subsidize another line. That is especially true if personal lines of insurance, such as auto and homeowners, are forced to pay for insolvencies in commercial lines such as workers' compensation or commercial liability. To the extent that practices common among writers in a particular line of insurance, such as underpricing of products to earn market share, contributed to the insolvency, those who did not participate in the practice should not be required to bear the losses it caused. Some also argue that merging accounts undermines regulatory efforts and reduces incentives for companies writing riskier lines of business to guard against insolvency, since other lines will share the cost. To protect the capacity of the guaranty association, it is critical for insurance regulators to maximize their efforts to oversee insurers. Although insurance regulators do not have full control over the actions of insurers domiciled outside their states, they do have authority to determine whether the insurer may write insurance in the state. One member of the subcommittee, Senator Beverly Bustin, argued strongly against the spillover assessment, which she views as an inappropriate cross-subsidization among lines of insurance.

The majority of the subcommittee, however, supported continuation of the spillover assessment. The need for an adequate assessment base to protect Maine policyholders, and information relating to the cause of recent insolvencies convinced the members that it was appropriate to spread the burden of insolvencies among all insurers in the MIGA.

Recent major insolvencies have not been caused primarily by problems endemic to one line of insurance. The Mission Insurance Co. insolvency, for example, has been blamed on excessive use of reinsurance, fraud, and mismanagement by the company. The details of Mission's operations during the 1980's are complex, and have been the subject of Congressional hearings, and extensive litigation. Briefly, it is believed

that Mission competed aggressively in the early 1980's, underpriced its products, knowingly accepted bad risks with the intent of earning profits from fees for managing a reinsurance pool, and with the intent to lay off the major risks on reinsurers to protect its own financial position.[22] Reinsurers, alleging that Mission's activities constituted fraud, have withheld over $2 billion dollars owed to the company. The failure of the reinsurers to honor their contracts caused the insolvency of the company.

A related insolvency was that of the Integrity Insurance Company. Integrity engaged in extensive use of Managing General Agents (MGA's). Over 80 MGAs had authority to underwrite risks in the name of the Integrity Insurance Company, without regulation by state insurance regulators, and with inadequate oversight or control by Integrity. As with Mission, Integrity undertook these writings with the intent to pass the risk on to reinsurers.[23] Integrity was reinsured by Mission Insurance Company, and when Mission failed, Integrity followed in insolvency.

American Mutual Insurance Company was a third insurer causing strain on the MIGA. American Mutual was writing primarily workers compensation (about 60% of its business) when it went insolvent, but its financial troubles came as a result of non-workers' compensation policies written much earlier. Those policies were written in "long-tail" lines of insurance, or lines in which claims often arise many years, or even decades after the policies are underwritten. For this reason, it is difficult for insurers to predict and anticipate losses in these lines of insurance.

In the 1940's, American Mutual wrote product liability policies, including coverage of asbestos manufacturers. After writing those policies, the company began writing medical malpractice, and later workers' compensation insurance. The strain of multiple asbestosis claims in the 1970's, coupled with the relative unprofitability of medical malpractice and workers' compensation, caused the company's insolvency in 1989.[24]

In considering these insolvencies, the subcommittee concluded that since the causes of the failure were not related to a specific line of insurance, it was not appropriate for any one line of insurers to bear the entire cost.

Furthermore, the subcommittee decided that the spillover assessment was a good middle ground between states with one account for all assessments, and those with strict separation of the accounts. Several smaller states, like Kansas, Kentucky, Montana and North Dakota have merged accounts for all purposes. Maine's approach is a hybrid, retaining initial responsibility in the line of insurance in which the insolvency occurred, but permitting a merging of accounts when a 2% assessment on the responsible account is insufficient to cover all costs.

Several members of the industry argue that, regardless of who pays the assessment initially, taxpayers should share the ultimate burden because guaranty association coverage benefits all people with claims against insurers, not just policyholders. For example, an injured worker may be receiving benefits from the insurer. Since society in general enjoys the protection of the fund it should also share in the cost. They also argue that state regulators will be more active in identifying and removing troubled insurers from the marketplace if they know that the taxpayers will bear the ultimate burden of insolvencies.

Opponents of a premium tax offset argue that the insurance industry has taken on responsibility for insuring its own industry and should continue to do so. The subcommittee did not feel that it was appropriate or feasible to permit a premium tax offset for assessments.

4. Circuit Breaker

When the "spillover" assessment was added to the MIGA statute in 1989, a circuit breaker mechanism was enacted to limit the size of the spillover assessment against small insurers. The purpose of the circuit breaker was to ensure that the special assessment did not impair the financial condition of small insurers. At the beginning of the interim study, the MIGA presented to the subcommittee a list of the companies that qualified for the circuit breaker in 1989, under current law, and the amount by which the assessment of each company was reduced as a result of the circuit breaker.

One of Maine's two major medical malpractice insurers, Medical Mutual Insurance Company, did not qualify for the circuit breaker. Although the company has surplus less than $12 million, it had more than $250,000 net income and a premium to surplus ratio less than 2:1. A representative of the company explained that the threshold requirement that an insurer have a premium to surplus ratio greater than 2:1 penalizes more conservative companies like Medical Mutual, which maintains a premium to surplus ratio of about 1:1 as a safety mechanism in a highly volatile line of insurance. He expressed concern to the subcommittee that, without the application of the circuit breaker, the relatively small number of policyholders of the company would be unreasonably burdened by the assessment against the company. Medical Mutual has approximately 1,100 policyholders, and a 1989 assessment liability of $337,000.

The subcommittee examined a proposal submitted by Medical Mutual that would expand the circuit breaker to insurers with less than $12 million of surplus and fewer than 3,000 policyholders.

Complete information on the number of insurers who would qualify for the proposed new circuit breaker, and the effect on non-qualified insurers was not available to the subcommittee during the time period of the study. Therefore, the subcommittee could not make a recommendation on any change in the circuit breaker. The circuit breaker amendment, however, is the subject of a bill that will be presented during the Regular Session, and the full Banking & Insurance Committee will consider the issue at that time. The Bureau of Insurance continues to work on collection and analysis of information and data for presentation to the committee when more complete information is available.

C. The Capacity of the MLHGA

The capacity of the life and health association raises some different issues from the capacity of the property/casualty fund. The primary function of the life/health fund is to provide for continuation of coverage for policyholders, not to pay claims. Thus, the level of exposure may differ. The scope of the capacity problem in the life/health fund was not apparent during the study. Maine has had little experience, and no problems with its life/health association to date. Nor has there been a problem nationally. Eden Sarfaty expressed his opinion to the subcommittee that there is no capacity problem in the life/health funds, although he agreed that the relative lack of major insolvencies in those lines may not hold true in the future.

1. Exposure

The subcommittee again examined the differences between the coverage of the Maine guaranty association and the NAIC Model Life/Health Guaranty Association Act. The two major issues discussed by the subcommittee involve the coverage of non-residents by the Maine fund and the inclusion of investment-related coverages.

Many life and annuity contracts and policies are used as investments, rather than as contracts intended to be held until a loss occurs, or until annuity payments are to begin. The purpose of the guaranty association is not to protect investment expectations of policyholder and contract holders, but to protect legitimate insurance objectives. The NAIC model Act was amended in 1985 in an attempt to separate and eliminate coverage of investment expectation from coverage of insurance. The subcommittee reviewed some of those changes.

Investment Expectations

The first change relates to insurer promises to pay a particular interest rate on individual contracts, such as life or annuity contracts. An insurer may promise large returns in order to attract purchasers. In some cases, like the Baldwin-United case, the insurer is unable for market reasons to make good on the promise and fails. It is not appropriate for solvent insurers and their policyholders to bear the costs through the guaranty association of unreasonable promises to the policyholders of insolvent insurers. The NAIC has therefore chosen an index, based on Moody's Corporate Bond Yield, which approximates a reasonable rate of earnings on an investment. This interest rate forms the ceiling that the guaranty association will back. The subcommittee agreed that this change should be adopted in Maine.

Coverage of Non-residents

The NAIC Model Act provides that each state pays for the claims of residents of that state. The rationale for this residents-only approach is that it spreads the burden of each insolvency over several states, and thereby assures sufficient capacity in all states. Maine statute provides that when a domestic insurer becomes insolvent, the Maine Life and Health Insurance Guaranty Association covers all policyholders, regardless of residence. Maine has few large domestic life/health insurers, so the chance of a major burden on the guaranty association because of this provision is relatively small. However, the subcommittee felt that it was appropriate to make this change to protect against possible future problems.

Substitute Coverage

The subcommittee discussed the NAIC Model Act provision which permits the guaranty association to alter the terms of covered policies, within certain parameters and with approval of the superintendent of insurance. The guaranty association may wish to change the terms if the policy is underpriced, for example, or to ease administration of an insolvency by providing somewhat uniform policies. The subcommittee felt that it was inappropriate to authorize changes in the policies, since the policyholder was promised certain terms, and the guaranty association's purpose is to assure continuation of those terms.

2. Assessment Base

The concerns and issues surrounding the assessment base of the life/health association are similar to those surrounding the property/casualty association. However, given the different function of the life/health fund, and the lack of experience in Maine with life/health insolvencies, there is no basis for predicting an insufficient assessment base in the

life/health fund. Eden Sarfaty told the committee that the assessment base in each account appears to him to be sufficient, and that assessment bases around the country have only been insufficient in one year to fund all claims when a single state of domicile of an insolvent insurer took responsibility for all policyholders of the insurer.

In addition to the difference in function between the property/casualty and the life/health associations, the ability of the insurers to recover assessments in the policy rates differs. Many of the policies written in the life/health area are long-term policies with fixed premium rates. Therefore, those premiums cannot be increased to recover assessments. Only newly-written policies and those shorter-term policies can be changed prospectively. Life/health insurers have, therefore, urged that assessments be recovered as an offset against premium taxes, and the NAIC Model provides a premium tax offset. Maine has not adopted the premium tax offset.

D. Recommendations for Change

After considering the issues described above, the subcommittee recommends that the following changes be made in coverage and assessments by the MIGA and the MLHGA, for the purpose of improving the capacity of the Associations.

1. Changes to the MIGA

Recommendation #1. Exclude coverage of the claims of affiliates of insolvent insurers.

The subcommittee believes that the guaranty association should not cover claims of affiliates of insolvent insurers because the affiliates are in a position to know the condition of the company that becomes insolvent and because, in some cases, the affiliate may "raid" the insurer's assets and then make a claim against the guaranty fund.

Recommendation #2. Provide for a $50 deductible on claims for unearned premium.

Unearned premium is that part of the premium paid for insurance coverage which is lost as a result of the insolvency. In other words, it is the premium paid in advance for the period from the insurer's insolvency to the termination of the policy period. Thirty-seven states have some type of deductible on coverage, generally $100. The subcommittee believes that a $50 deductible on unearned premium claims is appropriate in order to save administrative costs in processing small claims, and that the $50 deductible can generally be absorbed by policyholders without undue difficulty. A higher deductible could pose problems for some policyholders.

Recommendation #3. Exclude coverage of punitive damages.

Courts award punitive damages to persons injured by the action of others when the person causing the injury has acted with malice. The purpose of punitive damages is to punish the person who has committed the injury. Some insurance policies, however, will pay an insured's liability for punitive damages. The guaranty association could then be held liable to pay the damages if the insurance company becomes insolvent. The subcommittee believes that the guaranty association should not take over responsibility for paying punitive damages. That defeats the purpose of punitive damages by removing the punitive effect on the person causing the injury, and, it is further inappropriate to place the burden of payment on the policyholders who bear the burden of guaranty association assessments.

Recommendation #4. Remove the sunset on the spillover assessment.

The subcommittee believes that a 2% assessment in the separate accounts of the MIGA may not be sufficient in one or more years after 1990, that 2% is the most reasonable limit on assessments in any account in one year, and that it is therefore necessary to provide a "spillover" assessment, or a sharing of the burden of insolvencies in any one account. The subcommittee therefore recommends that the sunset on authority for the spillover assessment added by LD 750 be removed. The subcommittee believes that the spillover provision retains primary responsibility for assessments on the insurers writing the line of insurance in which the insolvency occurred. Moreover, the separation of life/health insurers from property/casualty insurers is retained.

Recommendation #5. Include coverage of marine "protection and indemnity" insurance.

Marine protection and indemnity is liability insurance for ocean-going vessels. It covers damage that ocean-going vessels cause to persons and property, and includes coverage under the federal Longshoremen's Act, which provides workers' compensation-like coverage to workers on ocean-going vessels. This should be covered like any other liability. The current statute excludes this coverage, which was not intended by proponents of the 1987 legislation that amended the statute.

2. Changes to the MLHGA

Recommendation #6. Exclude coverage of a portion of the interest guaranteed by a covered contract when the guaranteed rate exceeds a certain earnings index.

An insurer may sell life insurance or annuity contracts under which it guarantees that the policyholder will earn a certain rate if interest on its contributions. In certain instances, such as the Baldwin-United insolvency, the insurer has guaranteed an unrealistic interest rate, which may be a contributing factor or even the cause of the insolvency. It is not fair to solvent insurers to make good on those unrealistic promises of the insolvent insurer.

Recommendation #7. Exclude coverage of nonresidents when a domestic insurer becomes insolvent except when the insurer was never licensed in the nonresident's state, that state has a guaranty fund but the fund does not cover the nonresident.

Many states and the NAIC Model act require a state guaranty fund to cover only its own resident when a domestic insurer becomes insolvent. This residents-only approach spreads the effect of an insolvency out among the states, rather than placing the entire burden of an insolvency on anyone state. This helps assure that capacity to handle an insolvency will be sufficient in most if not all events.

Recommendation #8. Remove the sunset on the spillover assessment.

Although the MLHGA has not until 1989 been required to cover the costs of any insolvencies of life, health or annuity insurers, the subcommittee feels that it is not possible to exclude the possibility that the MLHGA could be hit with a major insolvency, and that the current 2% limit may not be sufficient to cover all likely assessments.

3. Other Recommendations

Recommendation #9. Require the Banking & Insurance Committee to examine the guaranty fund statutes in 1993.

The subcommittee believes that the insolvency of insurers is a matter which changes greatly from year to year. The capacity of the funds, and the legislature's policy judgments as to who should be covered and who should pay, may change as the pattern of insolvencies or lessons learned as a result of insolvencies are absorbed. Therefore the committee should examine how the changes made in 1989 and through this study will operate and whether additional changes are warranted given the experience between now and 1993.

Recommendation #10. Require the MIGA and MLHGA to report spillover assessments and annual total assessments.

The subcommittee believes that it is essential for the Legislature to be informed of the activities of the Guaranty Associations, especially with respect to the spillover assessments. The Banking & Insurance Committee was not aware that the MIGA borrowed $2.5 million in 1988 until the information was presented during discussions of LD 750. With more timely notice of extraordinary needs of the guaranty associations, such as the need to borrow money or to levy a spillover assessment, the committee may be better equipped to consider major legislation relating to the associations. For this reason, the subcommittee proposes that the MIGA and MLHGA notify the legislative committee with jurisdiction over insurance matters immediately of a vote to impose a spillover assessment. The associations would also be required to report annually to the committee on the total assessments and any borrowing made during the year.

V. IMPROVING INSURER OVERSIGHT

Subcommittee members expressed the belief from the outset of the study that the best way to protect the capacity of the guaranty associations is to minimize the activities in Maine of insurers likely to become insolvent. This would involve suspending or revoking the certificate of authority of insurers that are likely to become insolvent, or limiting their ability to write new business. The subcommittee asked the Bureau of Insurance to describe its current procedures for overseeing the financial condition of insurers that write policies in Maine, and talked with the Bureau and others to determine whether any changes to those procedures would be likely to improve Maine's ability to avoid insolvencies.

A. Current Oversight by the Bureau of Insurance

Once an insurer receives its initial certificate of authority to write one or more lines of insurance in Maine, it is required to make an annual report to the Bureau of its financial condition, transactions and affairs. It is also required to have an annual audit by an independent certified public accountant (CPA), and to file the audited financial report with the superintendent of insurance. This is true, regardless of whether the insurer is a "domestic" insurer or a "foreign" insurer. A company that is domiciled in Maine is called a "domestic" insurer; a company domiciled elsewhere is called a "foreign" insurer.

The Bureau is required to examine every authorized insurer as often as the superintendent deems necessary, but at least once every five years. Currently, the Bureau attempts to examine every "domestic" insurer in Maine every two to three years. The Bureau is authorized by law to accept the report of the insurance supervisory official of another state in lieu of conducting an examination of a foreign insurer, and generally does so, since the number of insurers writing in the state, and the resources available do not permit full examination of all foreign insurers.

For the most part, then, the protection that Maine receives from the insolvency of foreign insurers is only as great as the protection provided by the regulators of the state of domicile. Although the Bureau has authority to revoke or suspend the license of a foreign insurer writing in Maine, the Bureau rarely takes such action until the regulator of the state of domicile acts against the insurers. Unless an insurer fails to meet the capital or surplus requirements in Maine, the Bureau must prove that the insurer is in unsound condition or is using methods of practices hazardous or injurious to policyholders or the public in order to suspend or revoke the license. Without information or action from the state of domicile, the Bureau told the subcommittee that they would have a difficult time obtaining enough information to prove the case.

B. Proposals for Improvement

Recognizing that each state relies on the regulatory efforts of all other states, the NAIC has issued standards that it recommends for states to follow in regulating insurers. The subcommittee examined these standards and compared them to Maine's statutes and the Bureau's practices regarding regulation of the financial condition of insurers. For the most part, Maine's laws are consistent with the standards of the NAIC. In regulating domestic insurers, Maine's insurance regulators have generally been successful, suffering only one domestic insurer failure in the last 20 years.

Five areas of possible improvement in regulatory authority in Maine were noted, and the subcommittee discussed draft legislation for each of the five proposals. Although the subcommittee did not have sufficient time to fully explore the details of each proposal, they decided to include them in the draft legislation and to accept additional information and input during the hearing process on the bills. The subcommittee feels that strengthening insurer oversight is a necessary component of improving Maine's guaranty associations.

Recommendation #11: Require insurers to participate in the NAIC Insurance Regulatory Information System (IRIS).

Under the system, the NAIC collects raw data from all insurers in the United States, calculates certain ratios from the raw data, and distributes the ratios and analysis of the ratios to regulators in all states to assist them in overseeing the financial condition of insurers. The NAIC recommends that all states have a statutory requirement that insurers participate in IRIS. Currently, the Bureau of Insurance requires insurers to participate in IRIS, although there is no statutory requirement that they do so. The subcommittee recommends that this requirement be added to Maine law.

Recommendation #12: Permit the Superintendent of Insurance to have access to the audit work papers prepared by Certified Public Accountants (CPAs) during audits of insurers.

Although Maine law requires insurers to be audited annually by a CPA, and to submit an audited financial statement, it does not permit the Bureau of Insurance to have access to the working papers used in putting together the financial statement. The Bureau believes that the information in the working papers would permit them to oversee the financial condition of the insurer more fully without having to perform a full Bureau examination. Insurers felt that this may permit the Bureau to perform more efficient audits, and that insurers should share in the cost savings created by using the work papers.

The subcommittee discussed some of the concerns that accountants might have with this proposal. Realizing that accountants are prohibited by law from releasing working papers without client authorization, the subcommittee recommends that the insurers be required to provide access to the Bureau, not the accountant.

Recommendation #13. Strengthen Maine's law regarding credit for reinsurance.

In determining whether an insurer maintains sufficient assets to meet its liabilities, Maine statute allows insurers a credit for reinsurance either as an asset or as a reduction of liability. But because many reinsurers are alien (non-U.S.) insurers, they are not subject to regulation to the same extent as U.S. insurers. If a reinsurer refuses to honor its obligations to an insurer, the insurer may be unable to meet its obligations to its policyholders, and Maine law may have little or no ability to enforce the obligations of the reinsurer.

Maine statute currently limits the assuming insurers for which insurers may claims credit. But the proposal put before the subcommittee would make some changes to that current statute to strengthen it. The subcommittee agreed that strengthening reinsurance regulation is appropriate, especially in light of the Mission Insurance Company insolvency, which followed the refusal of reinsurers to honor over $2 billion of obligations to Mission.

Recommendation #14. Limit investments in "Junk Bonds" by Property/Casualty Insurers.

The financial health of an insurer depends not only on its premium income but on its ability to obtain income from investments. Over-investment in risky investments threatens the stability of an insurer. Current Maine law limits the investments of life/health insurers in junk bonds, but does not distinguish between junk bonds and other corporate obligations for non-life insurers. The proposal would distinguish between "investment grade corporate obligations" which are placed in one of the four top rating categories by an independent, nationally recognized rating agency, such as Moody's or Standard & Poor's, and "high yield" obligations, which have some element of security behind them, but are not highly rated by the national organizations.

Investments in "high yield " obligations would be limited so that the combination of an insurer's investment in high yield obligations, stocks and mutual funds does not exceed the insurer's surplus.

Recommendation #15. Require Third Party Administrators of health and other benefit insurance plans to be regulated by statute and licensed by the Bureau of Insurance.

Third Party Administrators (TPAs) act as service providers to insureds on behalf of insurance companies. They collect premiums, and process and pay claims pursuant to the terms of a contract with the insurer and under the terms of the insurance policy. TPAs are regulated by federal law when they provide services for self-insured plans, but they are not currently subject to federal or state regulation when they provide services with respect to insured plans. The subcommittee recommends that TPAs be regulated by the state Bureau of Insurance. Regulation would include a requirement that the TPA be licensed and bonded, maintain fiduciary accounts for their clients, and make certain reports to their clients.

C. Information Available to Aid Purchasers and Agents

The subcommittee explored whether it is possible for agents, in selling insurance policies, and purchasers in buying policies to know whether it is safe to purchase a policy from a particular insurer.

Representatives of agents' organizations told the subcommittee that they generally rely on the Bureau of Insurance's judgment about the financial soundness of an insurer. As long as the insurer has a certificate of authority to write insurance in Maine, the agent believes that it is not appropriate for them to counsel a purchaser not to buy a policy from a particular company. There is a network by which agents share information they have about insurers, but since the information may be based only on rumors, agents are concerned that acting on the basis of that information may subject them to liability for causing the insolvency of a company, or may interfere with attempts by the regulators to rehabilitate a company that is in trouble, but not insolvent.

The subcommittee also discussed the use of the NAIC "IRIS Ratios" by the Bureau of Insurance, agents and the public. The IRIS Ratios are a set of numbers calculated by the NAIC, on the basis of financial information reported to them by insurers. To those who know how to use them, they present part of the picture of the financial condition of an insurer. The Ratios include such ratios as premium to surplus, Two-Year Overall Operating Ratios, etc. The IRIS report available to the public also lists the mean (average) and median ratio for all insurers.

The NAIC calculates the ratios to enable it to help regulators identify insurers that need further regulatory attention, not as a guide to the quality of an insurer. After it calculates the ratios, the NAIC has a team of experts look at insurers that appear to be "outside the norm." Being

outside the norm does not in all events indicate that an insurer is headed for insolvency. The NAIC team reviews certain insurers and notifies regulators of the state of domicile of insurers the NAIC believes need further exploration.

There are limitations on the use of the Ratios, even by insurance experts. The numbers are only as accurate as the companies reporting them, and frequently numbers seem to indicate a problem when they really indicate a change in business practices or a particular transaction that have a temporary negative effect, but an overall positive one.

NOTES

1 When an insurer is unable to meet its obligations to policyholders, it is declared "insolvent". Insurance companies are not subject to federal or state bankruptcy laws, so state law governs the declaration of insolvency, as well as the liquidation or rehabilitation of the company after an order of insolvency.

2 Property/casualty insurance includes auto insurance, homeowners insurance, commercial liability, medical malpractice and other professional liability insurance, and workers' compensation insurance.

3 Unearned premium is the portion of premium that the policyholder has paid for coverage that is lost because of the insolvency.

4 For the sake of illustration, this explanation assumes that each state statute requires the guaranty association to cover all residents of the state, and only residents of the state. This is not always true. Some state statutes cover non-residents under certain circumstances; some states do not cover claims of their residents if the state of domicile of the insolvent insurer will cover all policyholders of the insurer, regardless of their residence. This interstate aspect of the guaranty fund statute is discussed more fully later in the report.

5 Because the funds are collected by the association only <u>after</u> there has been an insolvency, the system is referred to as a "post-insolvency" assessment , or "post-assessment" system. Only the state of New York has a "pre-insolvency," or "pre-assessment" system which allows the guaranty association to maintain funds on hand in anticipation of insurer insolvencies.

6 Property/casualty guaranty associations generally cover only residents and property located in the state, so guaranty association member insurers pay assessments in proportion to the premium they receive on policies issued to residents of the state or on policies issued for property located in the state. Some life/health associations cover residents <u>and</u> non-residents when a "domestic" insurer becomes insolvent, so the assessment is made separately for each state in which the insolvent insurer did business, and is assessed against member insurers on the basis of the insurer's premium in each individual state.

7 Kenneth Nails, "Guaranty Funds: The Growing Burden," Best's Review, July 1987.

8 24-A MRSA §4431-4451

9 24-A MRSA §4601-4618

10 39 MRSA §23-A

11 24-A MRSA §4440-A, sub-§3

12 Kenneth Nails, "Guaranty Funds: The Growing Burden," Best's Review, July 1987.

13 "State Insurance Guaranty Funds and Insurance Company Insolvency Assessment Information, 1969-1988," National Committee on Insurance Guaranty Funds (NCIGF)

14 Ibid.

15 Ibid.

16 National Organization of Life and Health Insurance Guaranty Associations (NOLHGA)

17 "State Insurance Guaranty Funds and Insurance Company Insolvency Assessment Information, 1969-1988," National Committee on Insurance Guaranty Funds (NCIGF)

18 Baldwin-United had 165,000 annuity holders, holding annuities with a face value of $3.4 billion. The types of policies and contracts written by the insurer caused the industry and the NAIC to reassess the coverage of life/health guarantee associations. See Rappaport, Insurance Company Solvency, Congressional Research Service, The Library of Congress, 1989

19 Information provided by the Maine Insurance Guaranty Association

20 Mission had provided "excess" coverage of workers compensation self-insurers. That is, employers who self-insured would pay benefits to injured workers up to a certain dollar amount. Mission promised to pay the "excess", that is, to pay any benefits due to the injured workers above the risk retained by the employer.

21 16 of Maine's 59 self-insurers had excess policies with Mission. Of those, 9 expected claims against the MIGA, 4 were small, 5 large.

22 Insurance Company Failures: Hearings before the Subcommittee on Oversight and Investigation of the House Committee on Energy and Commerce on the Failure of the Mission Insurance Company and the Integrity Insurance Company, 100th Cong., 2nd Sess. 100-227 (1988) (Staff Memorandum)

23 Ibid.

24 Telephone conversation between subcommittee staff and Roger Singer, Massachusetts Commissioner of Insurance at the time of the American Mutual insolvency, April 1989

VI. LIST OF EXHIBITS

Exhibit A: Authority for the Study: Legislative Council Correspondence and 1989 Public Law Chapter 67, Legislative Document 750, as amended by the Joint Standing Committee on Banking & Insurance and enacted by the Legislature.

Exhibit B: Assessments by the Maine Insurance Guaranty Association

Exhibit C: Proposed Legislation.
C-1 : Guaranty Association Law Changes
C-2: Changes in Insurer Oversight

Additional Materials Provided to the Subcommittee

Total Cumulative Assessments against Property/Casualty Insurers by Insurer Insolvency, 1969-1988, provided by the National Committee on Insurance Guaranty Funds (NCIGF).

Total Property/Casualty Insurer Assessments, Refunds and Net Assessments, 1969-1988, by State, provided by the NCIGF.

Life and Health Insurance Guaranty Association Assessments by Year, by Account, 1975-1988, provided by the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA).

Comparison between coverage provided by the MIGA and by the NAIC Model Property/Casualty Guaranty Association Act.

Comparison between coverage provided by the MLHGA and by the NAIC Model Life/Health Guaranty Association Act.

Examples of the Insurance Regulatory Information System (IRIS) Ratio Results, as provided by the NAIC.

NAIC Financial Regulation Standards, and Comparison of the NAIC Financial Regulation Standards with Maine statutes, and practices of the Maine Bureau of Insurance.

APPROVED
APR 27 '89
BY GOVERNOR

CHAPTER
67
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-NINE

S.P. 286 - L.D. 750

An Act to Amend the Laws Relating to the Maine Insurance Guaranty Association and the Maine Life and Health Insurance Guaranty Association

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the Maine Insurance Guaranty Association and the Maine Health and Life Insurance Association are organizations which provide guaranty funds which ensure payment of claims to covered individuals and organizations when insurers become insolvent; and

Whereas, the funding mechanism for these organizations needs to be modified to ensure that the guaranty funds will be sufficient to cover claims on an ongoing basis; and

Whereas, the funding mechanism needs to be modified immediately in order that the funds will have sufficient assets to cover claims of individuals insured by companies which have recently become insolvent; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

Sec. 1. 24-A MRSA §4433, sub-§2, as amended by PL 1987, c. 707, §§4-6, is further amended to read:

2. Exceptions. ~~Except that this~~ This subchapter shall not apply as to:

A. Contracts of reinsurance;

B. Mortgage guaranty insurance;

C. Credit insurance;

D. Insurance contracts procured as surplus lines coverage pursuant to chapter 19;

E. Title insurance; and

F. Financial guaranty insurance; and

G. Contracts of workers' compensation excess insurance issued to workers' compensation self-insurers approved under Title 39, section 23 by any insurer after the effective date of this paragraph, or in the case of a contract which automatically renews, not later than one year after the effective date of this paragraph.

Sec. 2. 24-A MRSA §4435, sub-§6, as amended by PL 1987, c. 769, Pt. B, §5, is further amended to read:

6. Member insurer. "Member insurer" means any authorized insurer which writes any kind of insurance to which this subchapter applies. If an insurer is authorized at the time of an insolvency and subsequently is approved to withdraw its license authority for the kinds of insurance covered by any account to which claims relating to the insolvency are allocated, the withdrawn insurer shall continue to be a member of each account solely for purposes of assessments relating to claims resulting from the insolvency until these claims are paid or otherwise extinguished.

Sec. 3. 24-A MRSA §4435, sub-§7, as amended by PL 1985, c. 279, §2, is further amended to read:

7. Net direct written premiums. "Net direct written premiums" means direct gross premiums written on insurance policies to which this subchapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers or premiums written through the United States Government Flood Insurance Program. For purposes of assessment against insurers pursuant to section 4440-B, "net direct written premium" means the average for the 5 calendar years prior to the year of assessment of premiums written on contracts of excess workers' compensation insurance issued to workers' compensation self-insurers approved under Title 39, section 23.

Sec. 4. 24-A MRSA §4435, sub-§§9 and 10 are enacted to read:

9. Line of credit. "Line of credit" means an irrevocable stand-by commitment whereby the association or member insurer and a qualified financial institution or group of qualified financial institutions enter into a formal and binding contract in which the qualified financial institution or group of qualified financial institutions agree to lend a certain amount of money within a stated period of time. The terms and conditions of any line of credit shall be established by rules adopted jointly by the Bureau of Banking and the Bureau of Insurance.

10. Qualified financial institution. "Qualified financial institution" means one which is insured by the Federal Deposit Insurance Corporation, Federal Savings and Loan Insurance Corporation or a successor federal deposit insurance agency or agencies, and has an equity capital to assets ratio of 6.5% or greater, as determined in accordance with generally accepted accounting principles.

Sec. 5. 24-A MRSA §4438, sub-§1, ¶C, as enacted by PL 1969, c. 561, is amended to read:

C. Allocate claims paid and expenses incurred among the 3 accounts separately; and assess member insurers separately for each account in amounts necessary to pay:

(1) The obligations of the association under paragraph A, subsequent to an insolvency, the obligations of the accounts for shortfalls under section 4440-A, and for preinsolvency assessments, if required by section 4440, subsection 3, paragraph B;

(2) The expenses of handling covered claims subsequent to an insolvency;

(3) The cost of examinations under section 4445; and

(4) Other expenses authorized by this subchapter;

Sec. 6. 24-A MRSA §4440, sub-§1, as amended by PL 1985, c. 279, §6, is further amended to read:

1. Proportion. The assessments of each member insurer provided for under section 4438, shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the same calendar year on the kinds of insurance in the account, except that assessments to cover a shortfall in any account shall be determined in accordance with section 4440-A. In the case of a withdrawn insurer, the average of its net direct written premium for the 5 calendar years prior to withdrawal shall be used as its assessment base for any year

following withdrawal in which the insurer has no net direct written premium.

Sec. 7. 24-A MRSA §4440, sub-§3, as enacted by PL 1969, c. 561, is repealed and the following enacted in its place:

3. Limitation; types of assessments. Assessments shall be made as follows.

A. Each member insurer may be assessed in any calendar year on any account an amount up to 2% of that member insurer's net direct written premiums for the next preceding calendar year on the kinds of insurance in the account for purposes of paying claims and expenses of that account.

B. To the extent that the maximum 2% has not been assessed, an assessment of up to that member's proportionate share of the applicable maximum as set forth in this paragraph shall be assessed when immediately necessary for the payment of claims and expenses. Any amount drawn by the association under any line of credit shall be considered a payment toward the member insurer's obligation provided for in this section. The maximum line of credit or preinsolvency assessment for each account shall be as follows:

Account	Maximum
Workers' compensation	$2,000,000
Automobile	$1,700,000
All other	$1,300,000

(1) The association shall obtain a line of credit for the benefit of each account, in an amount not to exceed the applicable maximum to ensure the immediate availability of funds for purposes of future claims and expenses attributable to an insurer insolvency in that account. The line of credit shall be obtained from qualified financial institutions. At no time may a qualified financial institution participate in the line of credit in excess of 20% of its equity capital. The line of credit shall provide for a 30-day notice of termination or nonrenewal to the superintendent and the association and shall provide funding to the association within one business day of receipt of written notice from the superintendent of an insolvent insurer in that account as defined in section 4435, subsection 5. Each member insurer upon receipt of notice from the association shall make immediate payment for its proportionate share of the amount borrowed based on the premium for the preceding calendar year. The line of credit provided for in this paragraph shall be subject to prior review and approval

by the superintendent at the time of origination and any subsequent renewal.

(2) If the association cannot obtain a line of credit, a member insurer may obtain a line of credit from a qualified financial institution or may extend a line of credit itself directly to and for the benefit of the member insurer's account by submitting to the association a duly authorized and executed line of credit agreement providing that the member insurer shall provide funding to the association under the line of credit within one business day of receipt of a written notice from the superintendent of an insolvent insurer as defined in section 4435, subsection 5, and receipt of a written request from the association for a drawdown under the line of credit. The line of credit agreement shall be subject to prior review and approval by the superintendent at the time of origination and any subsequent renewal. It shall include such commercially reasonable provisions as the association or the superintendent may deem advisable, including a provision that the line of credit is irrevocable or for a stated period of time and provides for a 30-day notice to the association and the superintendent that the line is being terminated or not renewed. Any line of credit issued under this paragraph may be replaced with another line of credit and the existing line of credit shall be released by the association once a substitute line of credit has been provided or the assessment provided for in this paragraph has been paid.

(3) If a line of credit is not given as provided for in subparagraph (2), the member insurer shall be responsible for payment of an assessment of up to that member's proportionate share of the applicable maximum as set forth in this paragraph which shall be paid into a preinsolvency assessment fund in each account. Funds in each account shall only be used for the payment of claims and expenses of an insolvent insurer in that account.

(4) All materials and information submitted or considered under this paragraph shall be matters of public record.

Sec. 8. 24-A MRSA §§4440-A and 4440-B are enacted to read:

§4440-A. Special assessment

1. Special assessment. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to

make all necessary payments from that account, the shortfall shall be assessed as an obligation of the other accounts of the association, with each member insurer's assessment to be in the proportion that its net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the accounts to be assessed bears to the total net direct written premiums of all member insurers for the same calendar year on the kinds of insurance in those accounts. The total of assessments against a member insurer under this section and section 4440 for any account in any one calendar year shall not exceed 2% of that member's net direct written premium on the kinds of insurance written in that account for the next preceding calendar year.

2. Limit on assessment. Subject to the 2% limitation, for any member insurer which has surplus of less than $12,000,000 and either a ratio of total net direct written premium to total surplus greater than 2 or net income of less than $250,000 for the year preceding the assessment, an assessment made under this section shall not exceed 5% of the average of that member insurer's net income over the 3 years prior to the year in which the assessment is made. For purposes of this subsection, "net income" means the sum of underwriting income and investment income, net of dividends to policyholders and federal and foreign income taxes incurred, as reported on the insurer's annual statement filed with the superintendent. "Total surplus" means surplus as regards policyholders, as reported on the insurer's annual statement filed with the superintendent.

3. Repealer. This section is repealed 91 days after adjournment of the Second Regular Session of the 114th Legislature.

§4440-B. Assessment of excess insurers

For purposes of assessments to pay claims resulting from policies of excess workers' compensation insurance issued to workers' compensation self-insurers, assessments shall include any authorized insurer which, at the time of the insolvency giving rise to those claims, was a member insurer and wrote one or more policies of excess workers' compensation insurance issued to workers' compensation self-insurers. This section is repealed on May 1, 1999.

Sec. 9. 24-A MRSA §4449, as amended by PL 1987, c. 707, §12, is further amended by adding a new paragraph at the end to read:

This section does not authorize a stay of proceedings before the Workers' Compensation Commission, or of proceedings in Superior Court to enforce orders of the Workers' Compensation Commission. A stay of workers' compensation proceedings before the Workers' Compensation Commission or the Superior Court may be

granted if otherwise authorized by law, provided that good cause for a stay exists and that reasonable diligence was exhibited by the insurer, the employer, the association and their counsel to proceed with the proceeding prior to the insolvency.

Sec. 10. 24-A MRSA §4605, sub-§6, as enacted by PL 1983, c. 846, is amended to read:

6. **Member insurer.** "Member insurer" means any person authorized to transact in this State any kind of insurance to which this chapter applies under section 4603. If an insurer is authorized at the time of an insolvency and subsequently is approved to withdraw its license authority for the kinds of insurance covered by any account to which claims relating to the insolvency are allocated, the withdrawn insurer shall continue to be a member of each such account for purposes of claims relating to the insolvency until these claims are paid or otherwise extinguished and shall be subject to Class B, Class C and Class E assessments attributable to these claims. In calculating assessments for any year after withdrawal in which the withdrawn insurer has no premium for any kind of insurance which is to be used as a basis for assessments under the terms of this chapter, the average of the withdrawn insurer's premium for the prior 5 calendar years shall be used as its basis for assessment.

Sec. 11. 24-A MRSA §4605, sub-§§11 and 12 are enacted to read:

11. Line of credit. "Line of credit" means an irrevocable stand-by commitment whereby the association or member insurer and a qualified financial institution or group of qualified financial institutions enter into a formal and binding contract in which the qualified financial institution or group of qualified financial institutions agree to lend a certain amount of money within a stated period of time. The terms and conditions of any line of credit shall be established by rules adopted jointly by the Bureau of Banking and the Bureau of Insurance.

12. Qualified financial institution. "Qualified financial institution" means one which is insured by the Federal Deposit Insurance Corporation, Federal Savings and Loan Insurance Corporation or a successor federal deposit insurance agency or agencies, and has an equity capital to assets ratio of 6.5% or greater, as determined in accordance with generally accepted accounting principles.

Sec. 12. 24-A MRSA §4609, sub-§2, as enacted by PL 1983, c. 846, is amended to read:

2. **Classes of assessments.** There shall be ~~3~~ 5 classes of assessments, as follows.

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

B. Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under section 4608 with regard to an impaired domestic insurer.

C. Class C assessments shall be made to the extent necessary to carry out the powers and duties of the association under section 4608 with regard to an impaired foreign or alien insurer.

D. To the extent that the maximum 2% has not been assessed, an assessment of up to that member's proportionate share of the applicable maximum as set forth in this paragraph shall be assessed when immediately necessary for the payment of claims and expenses. Payment of this assessment shall be assured by one of the means set forth in this paragraph. Any amount drawn by the association under any line of credit shall be considered a payment toward the member insurer's obligation provided for in this paragraph. The maximum line of credit or preinsolvency assessment for each account shall be as follows:

Account	Maximum
Life	$1,400,000
Health	$1,500,000
Annuity	$500,000

(1) The association shall obtain a line of credit for the benefit of each account, in an amount not to exceed the applicable maximum to ensure the immediate availability of funds for purposes of future claims and expenses attributable to an insurer insolvency in that account. That line of credit shall be obtained from a qualified financial institution. At no time may a qualified financial institution participate in a line of credit in excess of 20% of its equity capital. The line of credit shall provide for a 30-day notice of termination or nonrenewal to the superintendent and the association and shall provide funding to the association within one business day of receipt of notice from the superintendent of an impaired insurer in that account as defined in section 4605. Each member insurer upon notice from the association shall make immediate payment for its proportionate share of the amount borrowed based on the premium for the preceding calendar year. The line of credit provided for in this paragraph shall be subject to prior review

and approval by the superintendent at the time of origination and at any subsequent renewal.

(2) If the association cannot obtain a line of credit, a member insurer may obtain a line of credit from a qualified financial institution or may extend a line of credit itself directly to and for the benefit of the member insurer's account by submitting to the association a duly authorized and executed line of credit agreement providing that the member insurer shall provide funding to the association under the line of credit within one business day of receipt of a written notice from the superintendent of an impaired insurer as defined in section 4605 and receipt of a written request from the association for a drawdown under the line of credit. The line of credit agreement shall be subject to prior review and approval by the superintendent at the time of origination and at any subsequent renewal. It shall include such commercially reasonable provisions as the association or the superintendent may deem advisable, including a provision that the line of credit is irrevocable or for a stated period of time and provides for a 30-day notice to the association and the superintendent that the line is being terminated or not renewed. Any line of credit issued under this paragraph may be replaced with another line of credit and the existing line of credit shall be released by the association once a substitute line of credit has been provided or the assessment provided for in this paragraph has been paid.

(3) If a line of credit is not given as provided for in subparagraph (2), the member insurer shall be responsible for payment of an assessment of up to that member's proportionate share of the applicable maximum as set forth in this paragraph which shall be paid into a preinsolvency assessment fund in each account. Funds in each account shall only be used for the payment of claims and expenses of an insolvent insurer in that account.

(4) All materials and information submitted or considered under this paragraph shall be matters of public record.

E. Class E assessments shall be made to the extent necessary to carry out the powers and duties of the association under subsection 8.

Sec. 13. 24-A MRSA §4609, sub-§3, ¶A, as enacted by PL 1983, c. 846, is amended to read:

A. The amount of any Class A, Class D or Class E assessment for each account shall be determined by the board. The amount of any Class B or Class C assessment shall be divided among the accounts in the proportion that the present value of the liabilities for each account of the impaired insurer bears to the total liabilities of the impaired insurer. This paragraph shall not be a factor in the determination as to whether the protection provided by ~~statutes~~ 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.

Sec. 14. 24-A MRSA §4609, sub-§§5 and 6, as enacted by PL 1983, c. 846, are amended to read:

5. Additional assessment for abatements or deferrals. In the event an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth in subsection 4, the amount by which the assessment is abated or deferred~~,~~ shall be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. ~~If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in that 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.~~

6. Refunds. The board may, subject to the preinsolvency funding requirement of section 4609, subsection 2, paragraph D, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

Sec. 15. 24-A MRSA §4609, sub-§8 is enacted to read:

8. Assessment shortfalls. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any one account an amount sufficient to make all necessary payments from that account, the shortfall shall be assessed as an obligation of the other accounts of the association. Each member insurer's assessment shall be in the proportion that its premium for the calendar year preceding the assessment on the kinds of insurance in the

accounts to be assessed bears to the total premium of all member insurers for the same calendar year on the kinds of insurance in those accounts. The total of assessments against a member insurer for shortfalls under this section and section 4440 in any one calendar year shall not exceed 2% of that member insurer's premiums in this State or for policies covered by the account. This section is repealed 91 days after the adjournment of the Second Regular Session of the 114th Legislature.

Sec. 16. Legislative Study. The Joint Standing Committee on Banking and Insurance shall study the current operation of state guarantee funds and make recommendations to change or strengthen the current system. The committee shall study issues such as the feasibility of a circuit breaker on assessments and the appropriate manner of paying claims of insolvent insurers and self-insurers.

1. Study methods. In examining these issues, the committee may hold informational sessions and public hearings, determine and summarize legislative actions undertaken in other states, perform a survey of literature to determine alternative methods of assuring payment of insureds' claims, review historical data on assessments and claims payments of the associations and perform such other study as it deems appropriate.

2. Findings. The committee shall report its findings, together with any necessary implementing legislation, to the Second Regular Session of the 114th Legislature no later than December 1, 1989.

3. Staff assistance and funding. The committee shall request funding, staffing and clerical assistance from the Legislative Council. The Bureau of Insurance, the Maine Insurance Guaranty Association, the Maine Life and Health Insurance Guaranty Association and the Maine Self-insurance Guarantee Association shall provide information and assistance as needed to the committee.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.

STATE OF MAINE
ONE HUNDRED AND FOURTEENTH LEGISLATURE
COMMITTEE ON BANKING AND INSURANCE

June 6, 1989

Speaker John L. Martin
Chairman
Legislative Council

Dear Speaker Martin:

Earlier this session, the Joint Committee on Banking & Insurance reported out LD750, a bill revising the current mechanism for guaranteeing that persons insured by insolvent insurance companies receive payment for claims under their policies for life, health, workers' compensation and other property and casualty insurance. The legislation as introduced proposed a major overhaul of the state's Guarantee Fund mechanism. The committee, however, was not given adequate time to fully consider these major changes.

The committee dealt with LD750 in a crisis atmosphere, because the Guarantee Fund which provides payment to injured workers in the state, when their employer's workers' compensation insurer becomes insolvent, ran out of funds at the end of March. The company which sends checks to those injured workers was, according to the superintendent of insurance, threatening to stop sending checks unless some method was worked out to provide more funds to the Guarantee Fund. Thus, the committee agreed to a major change in the law, to alleviate the immediate crisis. We added to the bill a repeal date 91 days after adjournment of the 2and Regular Session of the 114th Legislature, and a provision requiring the committee to perform an interim study of the issue of guarantee funds. The sunset and the study were critical aspects of the bill which enabled us to deal with the immediate crisis with the assurance that we would have an opportunity to examine the issue more carefully during the interim. The interim study is necessary to fully consider the ramifications of the changes made to the structure, to review other models for guarantee funds, and to propose a viable, long-term structure for the funds which will

prevent future crises such as the one we recently suffered in the workers' compensation guarantee fund.

The bill requires the Committee to seek funding and staff from the Legislative Council in order to carry out the study. The purpose of this letter is to request staffing and funding to perform this proposed study, as set forth in the attached proposal.

Given the importance of this issue, and the impending sunset of the legislation at the end of the next legislative session, we urge the Legislative Council to approve this study request. Please let one of us know if you have any questions.

Sincerely,

Rep. Charlene Rydell
House Chair

Sen. Raynold Theriault
Senate Chair

3365m/DF

STATE OF MAINE
ONE HUNDRED AND FOURTEENTH LEGISLATURE
COMMITTEE ON BANKING AND INSURANCE

STUDY PROPOSAL FROM THE BANKING & INSURANCE COMMITTEE

The Joint Standing Committee on Banking and Insurance shall study the current operation of state guarantee funds and make recommendations to change or strengthen the current system. The committee shall study issues such as the feasibility of a circuit breaker on assessments and the appropriate manner of paying claims of insolvent insurers and self-insurers.

Study methods. In examining these issues, the committee may hold informational sessions and public hearings, determine and summarize legislative actions undertaken in other states, perform a survey of literature to determine alternative methods of assuring payments of insureds' claims, review historical data on assessments and claims payments of the associations and perform such other study as it deems appropriate.

Meetings. The Committee shall meet up to the number of times specified by the Legislative Council to perform the study.

Findings. The committee shall report its findings, together with any necessary implementing legislation, to the Second Regular Session of the 114th Legislature no later than December 1, 1989.

Compensation. Committee members shall receive legislative per diem and expenses, as defined in the Maine Revised Statutes, Title 3, section 2, for days of attendance at committee meetings. Members shall also receive reimbursement for travel and other necessary expenses upon application to the Executive Director of the Legislative Council.

Staffing. The Committee requests staffing and clerical assistance from the Legislative Council.

STATE OF MAINE

114th LEGISLATURE

LEGISLATIVE COUNCIL

July 6, 1989

Honorable Raynold Theriault, Senate Chair
Honorable Charlene B. Rydell, House Chair
Joint Standing Committee on Banking & Insurance
114th Maine Legislature

Dear Senator Theriault and Representative Rydell:

The Legislative Council met last Saturday to establish budgets for the approved interim study requests. The Council has taken the following actions on requests from your Committee:

Current Operation of State Guaranteed Funds — APPROVED

5 member subcommittee

3 subcommittee meetings
1 full committee meeting

The Council's action on all study requests is based on the understanding that the subcommittee will have completed its work by December 1, 1989. This means that the report and any accompanying legislation must be ready to transmit to the Legislative Council on that date.

I would ask that you send information regarding those members who will be serving on the study committees for the Study of Uninsured Motorists and the Feasibility of the State Fund as soon as it is available to Sally Diamond.

We appreciate your cooperation in moving quickly to organize the study and look forward to receiving your findings and recommendations. Please call me if you have any questions.

Sincerely,

John L. Martin, Chair
Legislative Council

cc: Martha Freeman, Director, Office of Policy & Legal Analysis

ASSESSMENTS BY THE MAINE INSURANCE GUARANTY ASSOCIATION

	AUTO		WORKERS' COMPENSATION		ALL OTHER	
	A	B	A	B	A	B
1971						
Maine Ins. Co.	$ 74,700	$ 74,700				
		(47,979)				
		$ ‹ 26,721›				
1979						
Professional Ins. Co.					$ 14,947	$ 14,947
						$ (3,400)
						(7,900)[10]
						$ ‹ 3,647›
Reserve Ins. Co./ Am. Res. Ins. Co.	$ 50,018	$ 50,018			$ 147,134	$ 147,134
						(80,000)
						(12,700)[10]
						(1,000)[10]
						(12,636)[11]
						(1,086)[11]
						$‹ 39,712›
1982						
Security Cas. Co.					$ 50,067	$ 50,067
						(40,000)[11]
						(2,000)[12]
						$ ‹ 8,067›

Column A: Amount Assessed or (Returned) in the Designated Year
Column B: Assessments and (Returns), All Years, and ‹Net Assessment› by Insolvent Insurer, as of December 1, 1989

	AUTO		WORKERS' COMPENSATION		ALL OTHER	
	A	B	A	B	A	B
Proprietors Ins. Co.	$ 20,000	$ 20,000 6,232[3] $ <26,232>			$ 3,000	$ 3,000 13,433[3] $ <16,433>
Professional Ins. Co.					$ (3,400)	[See 1979]
1984						
Ambassador Ins. Co.	$ 598,952	$ 598,952 (240,000)[11] (175,000)[12] $< 183,952>			$ 898,504	$ 898,504 250,000[3] (330,000)[12] $< 818,504>
1985						
Ideal Mutual Ins. Co.	$ 250,000	$ 250,000 50,000[3] 30,000[6] $< 330,000>	$200,000	$ 200,000 500,000[4] $ <700,000>	$ 200,000	$ 200,000 $ 200,000[2] 280,000[6] (100,000)[11] $< 580,000>
Reserve Ins. Co./ Am. Res. Ins. Co.					$ (80,000)	[See 1979]
Excalibur Ins. Co.		$ 30,000 25,0003 (1,500)[12] $ < 33,500>	$	$ 19,948[3]		

B2

	AUTO		WORKERS' COMPENSATION		ALL OTHER	
	A	B	A	B	A	B
1986						
Transit Cas. Co.	$ 100,000	$ 100,000 10,000[6] (80,000)[11] $< 30,000>	$ 200,000	$ 200,000 (100,000)[11] $< 100,000>	$ 200,000	$ 200,000 500,000[2] 200,000[3] $< 900,000>
Prof. Ins. Co.					$ (7,900)	[See 1979]
Reserve Ins. Co./ Am. Res. Ins. Co.					(12,700) (1,000)	[See 1979]
1987						
Proprietors Ins. Co.	$ 6,232	[See 1982]			$ 13,433	[See 1982]
Ambassador Ins. Co.	$ (240,000)	[See 1984]			$ 250,000	[See 1984]
Excalibur Ins. Co.	$ 25,000	[See 1985]	$ 19,948	[See 1985]		
Ideal Mutual Ins. Co.	$ 50,000	[See 1985]	$ 500,000	[See 1985]	$ (100,000) 200,000	[See 1985]
Transit Cas. Co.	$ (80,000)	[See 1986]	$ (100,000)	[See 1986]	$ 500,000 200,000	[See 1986]

B3

	AUTO		WORKERS' COMPENSATION		ALL OTHER	
	A	B	A	B	A	B
Carriers Ins. Co.			$ 450,000 165,000	$ 450,000[2] 165,000[3] $< 615,000>	$ 70,000	$ 70,000[3] 10,000 $ <80,000>
Midland Ins. Co.	$ 7,000	$ 7,000[3]	$ 200,000 140,000	$ 200,000[2] 140,000[3] $<340,000>	$ 200,000	$ 200,000[3] (32,000)[12] $< 168,000>
Great Global Assurance Co.					$ 6,000	$ 6,000[3]
American Druggists' Ins. Co.	$ 50,000	$ 50,000[3]	$ 225,000	$ 225,000[3]	$ 31,000	$ 31,000[3] (10,000)[12] $ < 21,000>
Allied Fidelity	$ 4,000	$ 4,000[3]				
Mission Ins. Co./ Mission National Ins. Co.			$ 558,000	$ 558,000[4] 2,132,596[5] 4,063,795[9] <$6,754,391>	$ 350,000	$ 350,000[3]
Integrity Ins. Co.	$ 200,000	$ 200,000[3]	$ 25,000	$ 25,000[3]	$ 15,000	$ 15,000[3]
Reserve Ins. Co./ Am. Res. Ins. Co.					$ (12,636) (1,086)	[See 1979]

B4

	AUTO		WORKERS' COMPENSATION		ALL OTHER	
	A	B	A	B	A	B
Security Cas. Co.					$ (40,000)	[See 1982]
1988						
Transit Cas. Co.	$ 10,000	[See 1986]				
Mission Ins. Co. Mission Natl Ins. Co.			$2,132,596	[See 1987]		
Carriers Ins. Co.					$ 10,000	[See 1987]
Ideal Mutual Ins. Co.	$ 30,000	[See 1985]			$ 280,000	[See 1985]
Ambassador Ins. Co.	$(175,000)	[See 1984]			$(330,000)	[See 1984]
Security Cas. Co.					$ (2,000)	[See 1982]
Midland Ins. Co.					$ (32,000)	[See 1987]
American Druggists' Ins. Co.					$ (10,000)	[See 1987]
Excalibur Ins. Co.	$ (1,500)	[See 1987]				

B5

	AUTO		WORKERS' COMPENSATION		ALL OTHER	
	A	B	A	B	A	B
1989						
Mission Ins. Co.			$4,063,795[9] [See 1987]			
American Mutual Ins. Co./	$ 100,000[7]				$1,000,000[7]	
Am. Mut. Liab. Ins. Co.	8,142,000[8]				7,891,000[8]	

B6

Key:

Assessments:

1 - Voted 12/30/85; Payable June, 1986

2 - Voted 10/21/86; Payable March 1, 1987

3 - Voted 10/20/87; Payable December, 1987

4 - Corrected 1987 Assessment of Workers' Compensation Account; original assessment was $5 million for Mission Ins. Co, $800,000 for Ideal Mutual Ins. Co. Credit was given for those amounts, and the corrected assessment was issued for $500,000 for Ideal, $558,000 for Mission.

5 - Voted 1/22/88; Payable out of 1987 overassessment.

6 - Assessed 1988; Information from Catherine Clifford

7 - Payable by letter dated April 3, 1989

8 - 1989 Spillover Assessment; Voted 8/21/89; Letter sent September 7, 1989

9 - 1989 Workers Compensation Account Assessment; $2,132,596 was voted on 1/5/89; payable by letter February 3, 1989; remainder was payable by letter dated May 23, 1989.

Returns:

10 - Returned by letter dated 11/25/86

11 - Returned by letter dated 11/3/87

12 - Returned 1988; Information from Catherine Clifford

Source: Pre-1985 Information from National Committee on Insurance Guaranty Funds (NCIGF); Other information from assessment letters from the MIGA to Member Insurers, and telephone conversations with Catherine Clifford, Treasurer of Guaranty Fund Management Services.

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SECOND REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document **No.**

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

AN ACT to Amend the Laws Relating to the Maine Insurance Guaranty Association and the Maine Life & Health Insurance Guaranty Association.

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

Sec. 1. 24-A MRSA §4433, sub-§1 is amended to read:

1. Application. This subchapter shall apply only as to the following kinds of insurance:

A. Property insurance, as defined in section 705;

B. Surety insurance, as defined in section 706;

C. Casualty insurance, as defined in section 707; and

D. Marine and transportation insurance, as defined in section 708, ~~except for~~ excluding wet marine insurance, as defined in section 708, subsection 2, but not excluding marine protection and indemnity insurance.

Sec. 2. 24-A MRSA §4435, sub-§1-A is enacted to read:

1-A. Affiliate. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year immediately before the year in which the insurer becomes an insolvent insurer.

Sec. 3. 24-A MRSA §4435, sub-§4 is amended to read:

4. Covered claim. "Covered claim" means an unpaid claim, including one for unearned premiums but excluding one for punitive damages, arising under and within the coverage and applicable limits of a policy of a kind of insurance referred

to in section 4433 to which this subchapter applies issued by an insurer which becomes an insolvent insurer after May 9, 1970, and where:

A. The claimant or insured is a resident of this State at the time of the insured event; or

B. The property from which the claim arises is permanently located in this State.

"Covered claim" shall not include any amount due any insurer, reinsurer, affiliate, insurance pool or underwriting association, as subrogation recoveries or otherwise.

Sec. 4. 24-A MRSA §4438, sub-§1, ¶A is amended to read:

A. Be obligated to pay covered claims existing prior to the determination of the insolvency or arising within 30 days after the determination of insolvency, or before the policy expiration date if less than 30 days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if within 30 days of the determination. The obligation shall be satisfied by paying to the claimant an amount as follows:

(1) ~~The~~ Except as provided in this paragraph, the full amount of a covered claim for benefits or unearned premium under workers' compensation insurance coverage;

(2) An amount not exceeding $100,000 per policy for a covered claim for the return of an unearned premium; or

(3) An amount not exceeding $300,000 per claim for all other covered claims.

In no event is the association obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. The Association shall pay only that amount of unearned premium in excess of $50. Notwithstanding any other provisions of this subchapter, a covered claim shall not include any claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer;

Sec. 5. 24-A MRSA §4440-A, sub-§3 is repealed.

Sec. 6. 24-A MRSA §4440-A, sub-§4 is enacted to read:

4. Notification to Legislature. Within 7 days after the Board of directors votes to levy an assessment under this section, the chair of the Board of directors shall notify the chairs of the legislative committee having jurisdiction over

insurance matters that the association has voted to make such an assessment. The notification must:

A. be in writing; and

B. include the total amount to be assessed against each account and the name of the account to which the assessed funds will be credited.

Sec. 7. 24-A MRSA §4452 is enacted to read:

§4452. Report to Legislature

At the end of each calendar year, the association shall submit a report of its activities to the legislative committee having jurisdiction over insurance matters. The report must include the amount of assessments made against each account, the name of the insolvent insurer to which the assessments are attributable, and the amount of funds borrowed, if any, by the association and the repayment date of any loan.

Sec. 8. 24-A MRSA §4603, sub-§1-A is enacted to read:

1-A. Persons Covered. This chapter shall provide coverage for the policies and contracts specified in subsection 1:

A. To any person (except for a non-resident certificate holder under a group policy or contract) who, is the beneficiary, assignee or payee of a person covered under paragraph B, and

B. To any person who owns, or is a certificate holder under, a policy or contract specified in subsection 1; or, in the case of an unallocated annuity contract, to a person who is the contract holder, and who:

(1) Is a resident, or

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

(i) The insurer that issued the policy or contract is domiciled in Maine;

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

(iii) The state has an association similar to the Maine Life and Health Insurance Guaranty Association; and

(iv) The person is not eligible for coverage by the association in that state.

Sec. 9. 24-A MRSA §4603, sub-§2 is amended to read:

2. Exceptions. This chapter shall not apply to:

A. That portion of a variable life insurance or variable annuity contract not guaranteed by an insurer;

B. Any such policies or contracts, or any part of these policies or contracts, under which the risk is borne by the policyholder;

C. Any such policy or contract or part thereof assumed by the impaired insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued; ~~and~~

D. Any such policy or contract issued by assessment mutuals and nonprofit hospital and medical service plans~~.~~ ; and

E. Any portion of a policy or contract to the extent that the rate of interest on which it is based:

(1) Averaged over a period of four years before the date on which the Association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged over the same four year period or for such lesser period if the policy or contract was issued less than four years before the Association became obligated; and

(2) After the date on which the Association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available.

Sec. 10. 24-A MRSA §4605, sub-§6-A is enacted to read:

6-A. Moody's Corporate Bond Yield Average. "Moody's Corporate Bond Yield Average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor to that index.

Sec. 11. 24-A MRSA §4608, sub-§8 is amended to read:

8. Assessment shortfalls. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any one account an amount sufficient to make all the necessary payments from that account, the shortfall shall be assessed as an obligation of the other accounts of the association. Each member insurer's assessment shall be in the proportion that its premium for the

calendar year preceding the assessment on the kinds of insurance in the accounts to be assessed bears to the total premium of all member insurers for the same calendar year on the kinds of insurance in those accounts. The total of assessments against a member insurer for shortfalls under this section and section 4440 in any one calendar year shall not exceed 2% of that member insurer's premiums in this State or for policies covered by the account. ~~This section is repealed 91 days after the adjournment of the Second Regular Session of the 114th Legislature.~~ Within 7 days after the Board of directors votes to levy an assessment under to this subsection, the chair of the Board of directors shall notify the chairs of the legislative committee having jurisdiction over insurance matters that the association has voted to make such an assessment. The notification must be in writing and must include the total amount to be assessed against each account, and the name of the account to which the assessed funds will be credited.

Sec. 12. 24-A MRSA §4619 is enacted to read

§4619. Report to Legislature

At the end of each calendar year, the association shall submit a report of its activities to the legislative committee having jurisdiction over insurance matters. The report must include the amount of assessments made against each account, the name of the insolvent insurer to which the assessments are attributable, and the amount of funds borrowed, if any, by the association and the repayment date of any loan.

Sec. 13. Study. During the First Regular Session of the 116th Legislature, the Joint Standing Committee on Banking & Insurance shall review this legislation and 1989 Public Law Chapter 67. To assist the committee, the Maine Insurance Guaranty Association and the Maine Life and Health Insurance Guaranty Association shall provide the committee with a report of the total assessments made between 1989 and the date of the report, the assessments made under the spillover assessment provisions of Title 24-A MRSA, sections 4440-A and 4608, any borrowing or other actions by the Associations necessary to fulfill their statutory obligations, and other information as the committee may specifically request.

STATEMENT OF FACT

This is one of two bills containing the recommendations of the Subcommittee to Study the Current Operation of State Guaranty Funds, a study subcommittee of the Joint Standing Committee on Banking & Insurance. This bill sets forth recommended changes in the statutes governing the Maine Insurance Guaranty Association and the Maine Life and Health Insurance Guaranty Association.

Guaranty associations are associations of insurers that assume the responsibilities of insolvent insurers. In 1989, the Maine Legislature enacted Public Law Chapter 67, which made major changes in the structure of the Maine Insurance Guaranty Association (MIGA) and the Maine Life & Health Insurance Guaranty Association (MLHGA). The changes were made to assure that sufficient funds would be available, through assessment of insurers, to pay the costs of insolvencies. The Subcommittee to Study the Current Operation of State Guaranty Funds reviewed the operation of the MIGA and the MLHGA statutes with the goal of determining what additional changes, if any, should be made to assure that goal.

The bill eliminates certain coverage of the guaranty associations, provides for continuation of the special assessment authority enacted in Public Law Chapter 67, and requires the Banking & Insurance Committee in 1993 to review this legislation and the 1989 legislation.

The bill makes the following changes to the statute governing the MIGA, which covers most property and casualty insurance:

1. Excludes coverage of affiliates of insolvent insurers. This avoids the possibility that an affiliate would drain the resources of an insurer, and then recover from the guaranty association;

2. Excludes coverage of punitive damages. Punitive damages are intended to punish the wrong-doer, and the wrong-doer should pay them, not a guaranty association;

3. Subjects claims for return of unearned premium to a $50 deductible. This would save administrative costs for the guaranty association without causing an undue financial burden for policyholders;

4. Specifically includes "marine protection and indemnity" coverage. This is comparable to general liability and workers' compensation coverage for ocean and inland water vessels, and should be covered the same as liability and workers compensation in any other context; and

5. Removes the sunset on the "spillover" assessment enacted by Public Law Chapter 67. The spillover assessment permits the MIGA to assess insurers writing all types of property/casualty insurance to pay for the insolvency of any one line of insurance when a 2% assessment of the insurers in that one line is not sufficient to cover all the costs. That spillover assessment is currently scheduled for repeal 91 days after the adjournment of the 1990 legislative session.

The bill makes the following changes in the MLHGA, which covers life, health and annuity policies and contracts:

1. Eliminates coverage of nonresidents when a domestic insurer (one domiciled in Maine) becomes insolvent, except under certain limited circumstances. Current Maine law requires the MLHGA to cover all policyholders of a Maine domestic insurer. Twenty-five of the 46 states with life/health guaranty associations cover only their own residents. Residents-only coverage spreads the costs of an insolvency among all states in which the insurer operates rather than requiring the state of domicile to bear the entire cost;

2. Provides that the guaranty association will not make good on an insolvent insurer's promise to pay an unreasonably high interest rate on a policyholder's investment in a life or annuity contract. The bill limits the coverage to an interest rate based on Moody's Corporate Bond Yield Average;

3. Removes the sunset on the spillover assessment in the Life and Health Fund for the same reasons as in the MIGA.

The bill requires both associations to immediately notify the legislative committee handling insurance matters of any "spillover" assessment, and to report annually on the assessments made by the association.

Finally, the bill requires the Banking & Insurance Committee to review the legislation in 1993.

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SECOND REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document **No.**

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

AN ACT to Improve Oversight of the Financial Condition of Insurers.

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

PART A

Sec. 1. 24-A MRSA §414, sub-§4 is enacted to read:

4. Insurance Regulatory Information System. Insurers required to file an annual statement must, as a condition to the issuance or continuance of a certificate of authority, provide the National Association of Insurance Commissioners with all information required for participation in the Insurance Regulatory Information System. Insurers shall provide written certification to the superintendent that they have complied with this subsection when they file their annual statements. This subsection does not apply to any insurer doing business under chapter 51.

PART B

Sec. 1. 24-A MRSA §1106, subsection 1 is amended to read:

1. Not less than 30% of the insurer's assets in aggregate amount shall consist of cash funds, agents' balances less than 90 days past due, and investments eligible under the following sections:

A. 1107 (public obligations);

B. 1108 (obligations, stock of certain federal and international agencies);

C. 1109 (investment grade corporate obligations);

D. 1112 (preferred or guaranteed stocks);

E. 1116 (trustees' or receivers' obligations);

F. 1117 (equipment trust certificates);

G. 1118 (acceptances, bills of exchange);

H. 1119 (savings and loan institutions);

I. 1120 (common trust funds, mutual funds);

J. 1124 (mortgage loans); and

K. 1126 (housing developments).

Sec. 2. 24-A MRSA section 1106, subsection 2 is amended to read:

2. The insurer shall not invest in aggregate amount in excess of its surplus as to policyholders in all investments eligible under the following sections:

A. 1113 (common stocks);

B. 1114 (insurance stocks);

C. 1115 (stocks of subsidiaries); ~~and~~

D. 1120, subsection 2 (mutual funds)~~.~~; and

E. 1109-A (high yield corporate obligations).

Sec. 3. 24-A MRSA §1109 is amended to read:

§1109. Investment grade corporate obligations

An insurer may invest in obligations, other than those eligible for investment under section 1124 (mortgage loans), issued, assumed or guaranteed by any solvent institution created or existing under the laws of the United States or of Canada, or of any state, province, district or territory thereof, ~~which~~ provided that the obligations are not in default as to principal or interest, are investment grade corporate obligations as defined in section 1162, subsection 6, and ~~which~~ are qualified under any of the following:

1. Obligations secured by adequate collateral security and bearing fixed interest and if during each of any 3, including either of the last 2, fiscal years of a period of not less than 3 nor more than 5 fiscal years next preceding the date of acquisition by the insurer, the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges, as defined in section 1110, shall have been not less than 1 1/4 times the total of its fixed charges for such year, or obligations which, at the date of acquisition by the

insurer, are adequately secured and have investment qualities and characteristics wherein the speculative elements are not predominant. In determining the adequacy of collateral security, not more than 1/3 of the total value of such required collateral shall consist of stock other than stock meeting the requirements of section 1112 (preferred or guaranteed stock).

2. Obligations secured by one or more leases, whether or not additionally secured by one or more mortgages, provided the following conditions are met:

A. The leases are assigned to the insurer or to a trustee acting on behalf of the insurer and are noncancellable by either party, except under provisions specified in the leases and designed to give adequate protection to the insurer's investment.

B. The aggregate rentals due under all such leases are sufficient to provide

(1) For all expenses (including taxes other than the borrower's income tax) of operation of the leased property during the initial term of such leases and

(2) For amortization during the initial term of such leases of not less than 90% of the investment (or 100% thereof if the investment is not also secured by a mortgage) with interest thereon.

C. The leases make suitable provisions for continuation of adequate payments throughout the life of the investment.

D. The lessees under such leases, or any corporation or instrumentality of government which has assumed or guaranteed the lessees' performance thereunder is such that its obligations would be eligible for investment by an insurer in accordance with section 1107 or the aggregate net earnings of such lessees available for fixed charges, as defined in section 1110, is at least equal to that required by subsection 1.

3. Fixed interest bearing obligations, other than those described in subsection 1, if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than 1 1/2 times its annual fixed charges applicable to such period and if during either of the last 2 years of such period such net earnings have been not less than 1 1/2 times its fixed charges for such year.

4. Adjustment, income or other contingent interest obligations if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition

by the insurer have averaged per year not less than 1 1/2 times the sum of its average annual fixed charges and its average annual maximum contingent interest applicable to such period and if during either of the last 2 years of such period such net earnings have been not less than 1 1/2 times the sum of its fixed charges and maximum contingent interest for such year.

5. Fixed interest bearing obligations, other than those described in subsections 1 and 3, if:

A. Net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than 1 1/4 times its average annual fixed charges applicable to such period and if during each of any 4 fiscal years of such period such net earnings have been not less than 1 1/4 times its fixed charges for such year;

B. The net earnings of such institution available for its fixed charges during a period of not less than 7 nor more than 10 fiscal years next preceding the date of acquisition by the insurer have been such that for each of any 7 fiscal years of such period such net earnings have been not less than 1 1/4 times its fixed charges for such year; and

C. The liquid assets of such institution have been not less than 105% of its liabilities, other than capital stock and surplus. For the purposes of this subsection, "liquid assets" and "liabilities" shall be determined in reliance upon the latest regular financial statement of the issuing, assuming or guaranteeing institution prepared as of a date not more than 15 months prior to the date of acquisition by the insurer; if net earnings are determined in reliance upon consolidated earnings statements of parent and subsidiary institutions, "liquid assets" and "liabilities" shall be determined in reliance upon a consolidated financial statement of parent and subsidiary institutions after treating any minority stock interest in such subsidiary institutions as a liability; and the term "liquid assets" shall mean the sum of cash, receivables or portions thereof, as the case may be, payable on demand or not more than 10 years after the date as of which the determination thereof is made for the purposes of this subsection, and readily marketable securities, in each case less applicable reserves and unearned income.

6. Fixed interest bearing obligations of financial companies, other than those eligible under subsections 1, 3 and 5, if either:

A.

(1) Net earnings of the issuing, assuming or guaranteeing institution available for its fixed

charges during each of the 5 fiscal years next preceding the date of acquisition by that insurer shall not have been less than 1 1/4 times its fixed charges for that year; and

(2) The liquid assets of that institution as of the end of the fiscal year covered in the latest regular financial statement of that institution prepared as of a date not more than 15 months prior to the date of acquisition by that insurer and as of the end of each of the 4 fiscal years next preceding that fiscal year shall have not been less than 95% of its liabilities, other than deferred income taxes, deferred investment tax credits, capital stock and surplus; or

B.

(1) Net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges during each of the 5 fiscal years next preceding the date of acquisition by that insurer shall have been not less than 1.15 times its fixed charges for that year; and

(2) The liquid assets of that institution as of the end of the fiscal year covered in the latest regular financial statement of that institution prepared as of a date not more than 15 months prior to the date of acquisition by that insurer and as of the end of each of the 4 fiscal years next preceding that fiscal year shall have been not less than 105% of its liabilities, other than deferred income taxes, deferred investment tax credits, capital stock and surplus.

A "financial company" is one having an average of at least 50% of its net income, including income derived from subsidiaries, over its last 5 fiscal years next preceding the date of acquisition by that insurer derived from the business of wholesale, retail, installment, mortgage, commercial, industrial or consumer financing, or from banking or factoring or similar or related lines of business.

For purposes of paragraph A, subparagraph (2) and paragraph B, subparagraph (2), if net earnings are determined in reliance upon consolidated financial statements of parent and subsidiary institutions, "liquid assets" and "liabilities" shall be determined in reliance upon a consolidated financial statement of parent and subsidiary institution after treating any minority stock interest in that subsidiary institution as a liability; and the term "liquid assets" shall mean the sum of cash, receivables or portions thereof, as the case may be, payable on demand or not more than 12 years following the close of the applicable fiscal year, and readily marketable securities, in each case less applicable reserves and unearned income.

Sec. 4. 24-A MRSA §1109-A is enacted to read:

§1109-A. High yield corporate obligations

Subject to the limitation set forth in section 1106, subsection 2, an insurer may invest in corporate obligations that are high yield obligations as defined in section 1162, subsection 4, provided the obligations meet the requirements of section 1109, except the requirement that the obligation be an investment grade obligation.

PART C

Sec. 1. 24-A MRSA §221-A, sub-§3, is amended to read:

3. Audits required. All insurers, excepting insurers transacting business in this State pursuant to the terms of chapter 51, shall cause to be conducted an annual audit by an independent certified public accountant and shall file an audited financial report with the superintendent on or before June 30th for the year ending December 31st preceding. An extension of the filing deadline may be granted by the superintendent upon a showing by the insurer or its accountant that there exists valid justification for such an extension. A firm of independent certified public accountants engaged to perform an audit of an insurer shall substitute the appointed audit partner-in-charge with another audit partner-in-charge respecting any engagement lasting more than seven years. No accountant substituted pursuant to this subsection may again serve as a partner-in-charge of that audit until two years from the date of substitution.

Sec. 2. 24-A MRSA §221-A, sub-§8, ¶A is amended to read:

A. The accountant immediately notify in writing ~~the chairman of~~ each member of the board of directors of the insurer and the superintendent upon any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported in the annual statement required under section 423 for the year ending December 31st preceding; and

Sec. 3. 24-A MRSA §414, sub-§5 is enacted to read:

5. The superintendent may require insurers subject to this section to make available any accountant's work papers created during an audit.

A. The superintendent may review the accountant's work papers upon timely notice to the insurer. The superintendent may photocopy or otherwise record the contents of work papers during the review.

B. Any work paper or copies of work papers under the superintendent's custody or control are confidential and are not subject to public inspection.

C. The work papers of an insurer's subsidiaries, parent or other corporate affiliates are deemed to be the insurer's work papers to the extent they reference transactions between the insurer and the subsidiary, parent or corporate affiliate and affect the insurer's final equity determination.

D. The insurer shall, as a condition of the accountant's engagement, require accountants:

(1) to retain any work papers prepared in connection with an audit of the insurer for at least six years after the close of a reporting period; and

(2) to provide the work papers, or a copy, to the insurer at the insurer's request, for the purposes of this subsection.

E. For purposes of this subsection, the term "work papers" includes, but is not limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of company records or other documents prepared or obtained by the accountant and the accountant's employees in conducting the examination of the insurer.

PART D

Sec. 1. 24-A MRSA §601, sub-§ 18 is enacted to read:

18. Third Party Administrators License.

A. Application fee $50

B. Annual fee $25

Sec. 2. 24-A MRSA chapter 18 is enacted to read:

Chapter 18

INSURANCE ADMINISTRATORS

§1901. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings:

1. "Administrator" means any person who, on behalf of a plan sponsor or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State in connection with any type of life, annuity, health or workers' compensation benefit provided

through or as an alternative to insurance within the scope of sections 702, 703 or 704 of this Title, or Title 39, other than any of the following:

A. An employer on behalf of the employer's employees or the employees of one or more subsidiary or affiliated corporations of the employer;

B. A union on behalf of its members;

C. A plan sponsor administering its own plan;

D. An insurance company that is:

(1) authorized to transact insurance in this state; or

(2) acting as an insurer with respect to a policy lawfully issued and delivered by that company in and pursuant to the laws of a state in which the insurer was authorized to transact an insurance business;

E. A health care services plan, health maintenance organization, professional service plan corporation, or person in the business of providing continuing care, possessing a valid certificate of authority issued by the Bureau of Insurance, and the sales representatives of those persons, plans, organizations, or corporations, if the activities of the plan, organization, corporation or person are limited to the activities permitted under the certificate of authority;

F. An insurance agent licensed in this state whose activities are limited to the scope of that license;

G. An adjuster licensed in this state whose activities are limited to the adjustment of claims;

H. A creditor on behalf of the creditor's debtors with respect to insurance covering a debt between the creditor and its debtors;

I. A trust and its trustees, agents, and employees acting pursuant to a trust established in conformity with 29 U.S.C. §186;

J. A trust exempt from taxation under §501(a) of the Internal Revenue Code, and the trustees and employees acting pursuant to that trust, or a custodian and its agents and employees, including individuals representing the trustees in overseeing the activities of a service company or administrator, acting pursuant to a custodial account which meets the requirements of §401(f) of the Internal Revenue Code;

K. A financial institution as defined in section 1514-A or a mortgage lender which collects and remits premium to licensed insurance agents or authorized insurers concurrently or in connection with mortgage loan payments;

L. A credit card issuing company which advances for, and collects premiums or charges from, its credit card holders who have authorized that collection if the company does not adjust or settle claims;

M. A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney and who does not collect charges or premiums in connection with life or health insurance coverage; and

N. A person who administers only single-employer self-insured life, annuity, or health benefit plans.

2. "Covered Individual" means any individual eligible for life, annuity, or health benefits under a plan.

3. "Contributions" means any money charged a covered individual, plan sponsor or other entity to fund the self-insured portion of any plan in accordance with written provisions of the plan or contracts of insurance. Contributions include administrative fees charged to a covered individual. "Administrative fee" means any compensation paid by a covered individual for services performed by the administrator.

4. "Premiums" means any money charged a covered individual, plan sponsor or other entity to provide life or accident or health insurance under a plan. The term premium shall include amounts paid by or charged to a covered individual plan sponsor or other entity for stop loss or excess insurance.

5. "Charges" means any compensation paid by a plan sponsor or insurer for services performed by the administrator.

6. "Administrator Trust Fund," referred to in this chapter as "ATF," means a special fiduciary account, established and maintained by an administrator under section 1909 in which contributions and premiums are deposited.

7. "Claims Administration Services Account," referred to in this chapter as "CASA," means a special fiduciary account established and maintained by an administrator under section 1909 from which claims and claims adjustment expenses are disbursed.

8. "Plan Sponsor" means any person other than an insurer, who establishes or maintains a plan covering residents of this State, including, but not limited to, plans established or maintained by 2 or more employers or jointly by one or more

employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. Notwithstanding the above, "plan sponsor" does not include:

A. The employer in the case of a plan established or maintained by a single employer; or

B. The employee organization in the case of a plan established or maintained by an employee organization.

No plan sponsor covered in whole by the Employee Retirement Income Security Act of 1974 (ERISA) shall be covered by any of the provisions of this chapter to the extent that the provisions of this chapter are inconsistent with or in conflict with any provisions of ERISA as now or hereafter amended.

9. "Plan" means any plan, fund or program established or maintained by a plan sponsor or insurer to the extent that the plan, fund or program was established or is maintained to provide through insurance or alternatives to insurance any type of life, annuity, health or workers' compensation benefit within the scope of sections 702 to 704 of this Title or Title 39.

10. "Quasi-resident" means a nonresident licensee who produces 50% or more of calendar year contributions and premium volume from residents of this State.

§1902. License required

No person may act as or hold himself out to be an administrator after July 1, 1990, unless licensed under this chapter. An administrator doing business in this State on July 1, 1990 shall apply for a license by October 1, 1990. In addition to any other penalty which may be imposed for violation of this Title, any person violating this section shall, upon conviction, be punished by a fine of not less than $100 nor more than $1,000 or by imprisonment for less than one year, or both.

§1903. Application

An applicant for a license shall file with the Superintendent an application upon a form prescribed by the Superintendent, which must include or have attached the following:

1. The names, addresses and official positions of the individuals who are responsible for the conduct of the affairs of the administrator, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation or the partners in the case of a partnership; and

2. A non-refundable filing fee as specified in section 601 which the superintendent shall apply toward the initial administrator license fee if an administrator's license is granted to the applicant.

§1904. Bond requirements for administrators

1. Every applicant for an administrator's license shall file with the application and shall thereafter maintain in force while so licensed, a fidelity bond in favor of the people of the State of Maine executed by a surety company and payable to any party injured under the terms of the bond. The bond shall be continuous in form and in one of the following amounts:

A. For an administrator that maintains an ATF but does not maintain a CASA, the greater of $50,000 or 5% of contributions and premiums projected to be received or collected in the ATF for the following plan year from Maine residents, but not to exceed $1,000,000;

B. For an administrator that maintains a CASA but does not maintain an ATF, the greater of $50,000 or 5% of the claims and claim expenses projected to be held in the CASA for the following year to pay claims and claim expenses for Maine residents, but not to exceed $1,000,000;

C. For an administrator that maintains an ATF and a CASA, the greater of the amounts determined under paragraphs (A) or (B) above, but not to exceed $1,000,000.

This subsection applies to an administrator who is required to maintain funds in a fiduciary capacity as set forth in Section 1909, unless the administrator has contracted with the insurer as an administrator and the plan is fully insured by the insurer on whose behalf the funds are held.

2. The bond must remain in force and effect until the surety is released from liability by the Superintendent or until the bond is cancelled by the surety. The surety may cancel the bond and be released from further liability under the bond upon 30 days' written notice in advance to the Superintendent. The cancellation shall not affect any liability incurred or accrued under the bond before the 30-day period expires. Upon receiving any notice of cancellation, the Superintendent shall immediately notify the licensee.

3. The administrator's license shall automatically terminate if the bond required by this section is not in force. Within 30 days after the bond ceases to be in force, the administrator shall return the license to the Superintendent for cancellation.

§1905. License

1. The Superintendent shall have a license issued to each applicant that complies with this chapter.

2. Unless revoked or suspended undersection 1907, an administrator license shall remain in effect as long as the holder of the license maintains in force and effect the bond required by section 1904 and pays the annual fee required by section 601 before to the anniversary date of the license.

3. Each license shall contain:

A. The name, business address and identification number of the licensee;

B. The date the license was issued; and

C. Any other information the Superintendent considers proper.

§1906. Administrator requirements

1. Each administrator shall identify to the Superintendent any ownership interest or affiliation of any kind with any plan sponsor or insurer responsible directly or through reinsurance for providing benefits to any plan for which it provides services as an administrator.

2. An administrator shall provide services as an administrator only pursuant to a written agreement between the administrator and the plan sponsor or insurer. The administrator shall retain the written agreement as part of its records for the duration of the agreement and for 5 years after the agreement expires.

3. An administrator shall maintain in its principal office for the duration of the written agreement with any plan sponsor or insurer and for 5 years after the agreement expires adequate books and records of all transactions involving a plan sponsor or insurer and covered individuals and beneficiaries. These books and records shall be maintained in accordance with generally accepted standards of business recordkeeping. An administrator is not required to maintain copies of books and records if the originals are returned to the plan sponsor or insurer before the end of the 5 year period. The administrator shall maintain evidence of the return of the originals for the balance of the 5 year period.

4. The administrator shall file with the Superintendent the names and addresses of the insurers and plan sponsors with whom the administrator has entered into written agreements. If an insurer or plan sponsor does not assume or bear the risk, the administrator must disclose the name and address of the

ultimate risk bearer. This subsection applies to the initial application for an administrator's license and any renewal of a license.

5. An administrator may use advertising pertaining to the plan only if it has been approved in advance by the plan sponsor or insurer.

6. Upon receiving instructions from the plan sponsor or insurer, an administrator shall deliver promptly to covered individuals or beneficiaries all policies, certificate booklets, termination notices or other written communications.

7. An administrator may not receive compensation from a plan sponsor or insurer which is contingent upon the loss ratio of the plan. This subsection does not, however, prevent the administrator from engaging in cost containment activities with a plan sponsor or insurer.

8. An administrator shall not receive from any plan sponsor, insurer, covered individual or beneficiary under a plan any compensation or other payments except as expressly set forth in the written agreement between the administrator and the plan sponsor or insurer.

9. Upon request of the Superintendent, an administrator shall make available for examination, either at the Bureau of Insurance or at the licensee's principal place of business, all basic organizational documents including, but not limited to articles of incorporation, articles of association, partnership agreements, trade name certificates, trust agreements, shareholder agreements and other applicable documents and all amendments to those documents, bylaws, rules and regulations or similar documents regulating the conduct of its internal affairs.

§1907. License suspension, revocation or denial

Any license issued under this chapter may be suspended or revoked, after notice to the licensee and an opportunity for hearing, and any application for license may be denied, after notice and opportunity for hearing:

1. For any of the grounds for suspension or revocation for license set forth in section 1539 for the suspension or revocation of licenses; or

2. If the licensee or applicant:

A. Is using any methods or practices in conducting its business that renders its further transaction of business in this State hazardous or injurious to covered individuals or the public;

B. Is affiliated with and is under the same general management as another administrator, that transacts business in this State without being licensed under this chapter; or

C. Has failed to report a conviction as required by section 1908.

§1908. Criminal convictions

Any administrator and any individual listed on the application as required by section 1903 who is convicted of a crime punishable by imprisonment for more than one year shall report that conviction to the Superintendent within 30 days after judgment is entered. Within that 30 day period, the administrator shall also provide the Superintendent with a copy of the judgment and any commitment order and any other relevant documents relating to disposition of the criminal action.

§1909. Fiduciary accounts and duties

1. Administrators shall hold in a fiduciary capacity all contributions and premiums received or collected on behalf of a plan sponsor or insurer. These funds shall not be used as general operating funds of the administrator. All contributions and premiums received or collected by the administrator from residents of this State, which the administrator holds more than 15 days or deposits into an account which is not under the control of the plan sponsor or insurer, shall be placed in a special fiduciary account, designated as an "Administrator Trust Fund Account". All resident and quasi-resident licensees required to maintain an ATF under to this section shall maintain the ATF with one or more financial institutions located within the State and subject to jurisdiction of the courts of this state. Funds belonging to 2 or more plans may be held in the same ATF, provided the administrator's records clearly indicate the funds belonging to each plan. Checks drawn on the ATF shall indicate on their face that they are drawn on the administrator's ATF.

2. The administrator may make the following disbursements from the ATF:

A. Contributions and premiums due insurers or other persons providing life, accident and health, or workers' compensation coverage for a plan;

B. Return contributions and premiums to a plan or covered individual;

C. Commissions or administrative fees due to the administrator when earned under a written agreement; and

D. Transfers into the CASA of the administrator.

3. For each plan for which an ATF is required, the balance in the ATF must at all times be the amount deposited plus accrued interest, if any, less authorized disbursements. If the balance at the financial institution with respect to the ATF is less than the amount deposited plus accrued interest, if any, less authorized disbursements, the administrator is presumed, for purposes of license revocation or suspension, to have misappropriated funds and to have acted in a financially irresponsible manner.

4. Before establishing an AFT that is interest bearing or income producing, the administrator must disclose the nature of the account to the plan sponsor or insurer on whose behalf the funds will be held. The administrator must secure written consent and authorization from the plan sponsor or insurer for the investment of the money and disposition of the interest or earnings. An administrator may not make any investment which assumes a risk other than the risk that the obligor may not pay the principal when due. The administrator may not use specialized techniques or strategies which incur additional risks to generate higher returns or to extend maturities. Such techniques include, but are not limited to, the use of financial futures or options, buying on margins and pledging of ATF balances.

5. Administrators may place ATF funds in interest bearing or income producing investments and retain the interest or income on the funds, provided the administrator obtains the prior written authorization of the plan sponsors or insurers on whose behalf the funds are to be held. In addition to savings and checking accounts, an administrator may invest in the following:

A. Direct obligations of the United States of America or U.S. Government agency securities with maturities of not more than one year;

B. Certificates of deposit, with a maturity of not more than one year, issued by financial institutions insured by the Federal Deposit Insurance Corporation (FDIC) or Federal Savings and Loan Insurance Corporation (FSLIC), provided any such deposit does not exceed the maximum level of insurance protection provided to certificates of deposit held by those institutions;

C. Repurchase agreements with financial institutions or government securities dealers recognized as primary dealers by the Federal Reserve System provided:

(1) The value of the repurchase agreement is collateralized with assets which are allowable investments for ATF funds;

(2) The collateral has a market value at the time the repurchase agreement is entered into at least equal to the value of the repurchase agreement; and

(3) The repurchase agreement does not exceed 30 days.

D. Commercial paper, provided the commercial paper is rated at least P-1 by Moody's Investors Service, Inc. or at least A-1 by Standard & Poor's Corporation; or

E. Money Market Funds, provided the money market fund invests exclusively in assets which are allowable investments pursuant to paragraphs A through D for ATF funds.

Each investment transaction must be made in the name of the administrator's ATF. The administrator must maintain evidence of any such investments. Each investment transaction must flow through the administrator's ATF.

6. The administrator shall hold in a fiduciary capacity all money that the administrator receives to pay claims and claim adjustment expenses. All resident and quasi-resident licensees shall place all such money for claims and claim adjustment expenses for residents of this State, whether received from a plan sponsor or insurer or from the administrator's ATF, in a special fiduciary account in a financial institution located in this State. The account shall be designated a "Claims Administration Service Account" . Funds belonging to 2 or more plans may be held in the same CASA, provided the administrator's records clearly indicate the funds belonging to each plan. Checks drawn on the CASA must indicate on their face that they are drawn on the administrator's CASA.

7. No deposit may be made into a CASA and no disbursement may be made from a CASA except for claims and claim adjustment expenses. For each plan where a CASA is required, the balance in the CASA must at all times be the amount deposited less claims and claims adjustment expenses paid. If the CASA balance is less than such amount, the administrator shall be presumed, for purposes of license revocation or suspension, to have misappropriated funds and to have acted in a financially irresponsible manner.

8. Administrators shall maintain detailed books and records which reflect all transactions involving the receipt and disbursement of:

A. Contributions and premiums received on behalf of a plan sponsor or insurer; and

B. Claims and claim adjustment expenses received and paid on behalf of a plan sponsor or insurer.

9. The detailed preparation, journalizing and posting of books and records required by subsection 8 shall be maintained on a timely basis and all journal entries for receipts and disbursements shall be supported by evidential matter, which must be referenced in the journal entry so that it may be traced for verification. Administrators shall prepare and maintain monthly financial institution account reconciliations of any ATF and CASA established by the administrator. The reconciliation must include, at a minimum, the following:

A. The source and amount of any money received and deposited by the administrator, and the date of receipt and deposit;

B. The date each disbursement was made, the person to whom the disbursement was made, and a written explanation of any difference between the amount disbursed and the amount billed or authorized; and

C. A description of the disbursement in sufficient detail to identify the source document substantiating the purpose of the disbursement.

10. Failure to accurately maintain the required books and records in a timely manner is deemed to be untrustworthy, hazardous or injurious to participants in the plan or the public and financially irresponsible.

11. This section does not apply to nonresident administrators who are subject to substantially similar requirements in their state of domicile.

§1910. Unauthorized activities

Nothing in this chapter may be construed to permit any person or entity to receive or collect charges, contributions or premiums for, or adjust or settle claims in connection with, any type of life or accident or health benefit, unless the person or entity is authorized through the insurance laws of a state or the Employee Retirement Income Security Act of 1974, 29 USC par. 1001 et seq. as amended, to provide those benefits.

PART E

Sec. 1. 24-A MRSA §731 is repealed.

Sec. 2. 24-A MRSA §731-A is enacted to read:

§731-A. Acceptance of reinsurance

An insurer may accept reinsurance only of such kinds of risks, and retain risk thereon within such limits, as it is otherwise authorized to insure.

Sec. 3. 24-A MRSA §731-B is enacted to read:

731-B. Credit for reinsurance

1. Credit for reinsurance will be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurance is ceded to a solvent assuming insurer that:

A. Is licensed to transact insurance or reinsurance in Maine, provided the insurer has surplus to policyholders in an amount not less than the paid-in capital stock required of an authorized foreign stock insurer transacting like kinds of insurance; or

B. Is licensed in at least one state that employs standards regarding credit for reinsurance substantially similar to those applicable under this section, provided the insurer has surplus to policyholders in an amount not less than the paid-in capital stock required of an authorized foreign stock insurer transacting like kinds of insurance; or

C. Maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest.

(1) The assuming insurer shall report annually to the superintendent information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers to enable the Commissioner to determine the sufficiency of the trust fund.

(2) In the case of a single assuming insurer, the trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of at least $20,000,000.

(3) In the case of a group of individuals who constitute a syndicate of unincorporated alien underwriters, the trust must consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of at least $100,000,000. The group shall make available to the superintendent an annual certification by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter.

(4) The trust must be established in a form approved by the superintendent. The trust instrument must provide that contested claims are valid and

enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the superintendent. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(5) The trustees of the trust shall report to the superintendent in writing by February 28 of each year, setting forth the balance of the trust and listing the trust's investments at the end of the preceding year and certifying the date of termination of the trust, if so planned, or certifying that the trust will not expire before December 31 of the current year.

(6) The corpus of the trust shall be valued as any other admitted asset or assets.

2. The credit permitted by subsection 1 will not be allowed unless the assuming insurer agrees in the reinsurance agreements:

A. That if the assuming insurer fails to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer:

(1) Will submit to the jurisdiction of any court of competent jurisdiction in any State of the United States;

(2) Will comply with all requirements necessary to give the court jurisdiction; and

(3) Will abide by the final decision of the court or of any Appellate Court in the event of an appeal; and

B. To designate the superintendent or an attorney as its attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company, as required in section 421.

This provision is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

3. A reduction from liability for the reinsurance ceded to an assuming insurer not meeting the requirements of subsection 1 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall equal the

value of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the contract, if such security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution. This security may be in the form of:

A. Cash;

B. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets; or

C. Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, provided the Securities Valuation Office of the National Association of Insurance Commissioners has determined that the institution meets the standards that it determines necessary and appropriate to the quality of a financial institution issuing letters of credit for this purpose.

(1) A letter of credit from an issuer determined to be acceptable as of the date of issuance or the date of confirmation of the letter shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until its expiration, extension, renewal, modification or amendment, whichever first occurs. The ceding insurer shall replace a non-qualifying letter of credit at its earliest opportunity.

(2) The letter of credit must indicate that it is not subject to any condition or qualification outside the letter of credit, and that the beneficiary need only draw a sight draft under the letter and present it to obtain funds and that no other document need be presented.

4. For purposes of this section, "qualified United States financial institution" means an institution that:

A. Is organized, or in the case of a U.S. branch or agency office of a foreign banking organization licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers; and

B. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

5. Credit shall be allowed as an asset or deduction from liability to any ceding insurer only for reinsurance ceded to an assuming insurer qualified under this section, except that no credit shall be allowed, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer.

6. This section does not apply to wet marine and transportation insurance.

7. The superintendent may adopt rules, subject to Title 5, chapter 375, implementing this section.

Sec. 4. 24-A MRSA §731-C is enacted to read:

§731-C. Bulk reinsurance

The cession of bulk reinsurance by a domestic insurer is subject to section 3483.

Sec. 5. 24-A MRSA §731-D is enacted to read:

§731-D. Notification of reinsurance changes

Upon request of the superintendent, an insurer shall promptly inform the superintendent in writing of the cancellation or any other material change of any of its reinsurance treaties or arrangements.

Sec. 6. 24-A MRSA §3483, sub-§6 is enacted to read:

6. The superintendent may adopt rules, subject to Title 5, chapter 375, to effectuate this section.

STATEMENT OF FACT

This is one of two bills containing the recommendations of the Subcommittee to Study the Current Operation of State Insurance Guaranty Funds of the Joint Standing Committee on Banking & Insurance. This bill includes recommendations for improvements in the oversight of insurers.

Part A of the bill requires insurers to provide information to the National Association of Insurance Commissioners, the NAIC, to enable that organization to operate the Insurance Regulatory Information System (IRIS). IRIS assists insurance regulators in overseeing the financial condition of insurers by collecting, analyzing and distributing certain financial information about all insurers in the United States. Although Maine insurers currently provide the necessary information to the NAIC, there is no statutory requirement that they do so. The subcommittee recommends that this requirement be added to Maine law.

Part B of the bill amends the law regulating investments by insurers, to include a limit on the amount of "junk bonds" that an insurer may invest in. The bill would limit investment in bonds which are not rated by a nationally recognized rating agency, such as Standard & Poor's, but which otherwise meet the security requirements of Maine statute, in the same way that it limits investment in stocks. Current law limits investment in stocks and other riskier investments so that the aggregate amount invested in such vehicles may not exceed the insurer's surplus as regards policyholders.

Part C of the bill relates to audits of insurers by certified public accountants. Although Maine law requires insurers to be audited annually by a CPA, and to submit an audited financial statement, it does not require insurers to grant the Bureau of Insurance access to the working papers used in putting together the financial statement. This bill would require the insurer to provide access to the work papers,to enable the Bureau to oversee the financial condition of the insurer more fully without having to perform a full Bureau examination. Work papers in the custody of the superintendent would be confidential, and not subject to public inspection. The bill also requires the CPA firm to rotate the partner in charge of an audit every seven years, and requires the CPA to notify all members of the Board of Directors of an insurer if the CPA determines that the insurer has materially misstated its financial condition on its annual statement. Current law requires notification of only the chairman of the Board.

Part D of the bill enacts a new chapter in the Insurance Code to regulate Third Party Administrators. TPAs are persons or companies that provide administrative services to insurers and self-insurers in operation of health, life and annuity plans, and workers' compensation benefit programs. Depending on the agreement between the TPA and the insurer or plan sponsor, the TPA may collect and remit premiums to the insurer or assets manager of a self-insured plan, process and pay claims in accordance with the provisions of the plan or insurance contract, or any combination of these actions. Although the federal Employee Retirement Income Security Act (ERISA) regulates TPAs in some ways in their dealings with self-insured plans, there is no state law regulation of TPAs or regulation of their actions with respect to insured plans.

This bill would require TPAs to be licensed by the Bureau of Insurance, and to file a bond with the State that would be payable to any person injured by the TPAs actions. If the TPA is acting under a contract with an insurer, for a fully insured plan, and the TPA only handles money of the insurer, no bond would be required. The bill would require the TPA to maintain a fiduciary account for the deposit of all premiums collected, and all money held by the TPA for the purpose of paying claims. The bill contains guidelines for recordkeeping of transactions and payments by the TPAs.

Part E of the bill amends the law relating to credit for reinsurance ceded by an insurer. The bill makes the following changes in the standards that must be met for a ceding insurer to obtain credit for insurance ceded to an assuming insurer: the assuming insurer would have to agree in a reinsurance agreement to submit to jurisdiction of any court in any state; the amount of the required trust for a single assuming insurer that is not licensed in Maine or a state with comparable standards would be increased from $10 million to $20 million; the trust form and reporting requirements would be tightened; and the proposal would explicitly provide for a reduction from liability for reinsurance ceded to insurers not meeting the requirements of statute, under certain circumstances.

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