

House Bill 1050

By: Representatives Lumsden of the 12th, Carson of the 46th, Hawkins of the 27th, Taylor of the 173rd, and Williams of the 148th

A BILL TO BE ENTITLED
AN ACT

1 To amend Chapter 38 of Title 33 of the Official Code of Georgia Annotated, relating to
2 Georgia Life and Health Insurance Guaranty Association, so as to extend association
3 protections to certain persons receiving insurance coverage from health maintenance
4 organization subscriber contracts or health care corporation plans; to provide for
5 applicability; to provide for modernization and updates; to provide for revisions to the
6 assessment formula on long-term care insurance written by impaired or insolvent insurers;
7 to provide for the recoupment of assessments on certain members through a surcharge on
8 premiums as approved by the Commissioner; to provide for definitions; to provide for related
9 matters; to repeal conflicting laws; and for other purposes.

10 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

11 style="text-align:center">**SECTION 1.**

12 Chapter 38 of Title 33 of the Official Code of Georgia Annotated, relating to Georgia Life
13 and Health Insurance Guaranty Association, is amended by revising Code Section 33-8-1,
14 relating to purpose, as follows:

15 "33-38-1.

16 The purpose of this chapter is to protect the persons specified in subsection (b) of Code
17 Section 33-38-2, subject to certain limitations, against failure in the performance of
18 contractual obligations, under life ~~and~~, health ~~insurance policies~~, and annuity policies,
19 plans, or contracts specified in subsection (a) of Code Section 33-38-2, due to the
20 impairment or insolvency of the member insurer issuing such policies, plans, or contracts.

21 To provide this protection; (1) an association of member insurers is created to enable the
22 guaranty of payment of benefits and continuation of coverages as limited by this chapter; (2)
23 members of the association are subject to assessment to provide funds to carry out the
24 purpose of this chapter; and (3) the association is authorized to assist the Commissioner,
25 in the prescribed manner, in the detection and prevention of insurer impairments or
26 insolvencies."

SECTION 2.

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Said chapter is further amended by revising Code Section 33-38-2, relating to scope, as follows:

"33-38-2.

(a) This chapter shall provide coverage to the persons specified in subsection (b) of this Code section for policies or contracts of direct, nongroup life insurance; health, or annuity policies or contracts, insurance which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates and health care plans issued by health care corporations; annuities; for certificates under direct group policies and contracts and ~~for~~ supplemental contracts to any of these; and for unallocated annuity contracts, in each case issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(b)(1) Coverage under this chapter shall be provided only:

(A) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subparagraph (B) of this paragraph; and

(B) To persons who are owners of or certificate holders or enrollees under such policies or contracts, other than unallocated annuity contracts and structured settlement annuities, to the persons who are the contract holders and who:

(i) Are residents; or

(ii) Are not residents, but the member insurers which issued such policies or contracts are domiciled in this state; the states in which such persons reside have associations similar to the association created by this ~~article~~ chapter; and such persons are not eligible for coverage by an association in any other state due to the fact that the insurer, health maintenance organization, or health care corporation was not licensed in the state at the time specified in the state's guaranty association law.

(2) For unallocated annuity contracts specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to:

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

66 (B) Persons who are owners of unallocated annuity contracts issued to or in connection
 67 with government lotteries if the owners are residents.

68 (3) For structured settlement annuities specified in subsection (a) of this Code section,
 69 subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this
 70 chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide
 71 coverage to a person who is a payee under a structured settlement annuity, or beneficiary
 72 of a payee if the payee is deceased, if the payee:

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

74 (B) Is not a resident, but only under both of the following conditions:

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

76 (II) The contract owner of the structured settlement annuity is not a resident, but the
 77 insurer that issued the structured settlement annuity is domiciled in this state and the
 78 state in which the contract owner resides has an association similar to the
 79 association created by this chapter; and

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

82 (4) This chapter shall not provide coverage to:

83 (A) A person who is a payee or beneficiary of a contract owner who is a resident of this
 84 state, if the payee or beneficiary is afforded any coverage by the association of another
 85 state; ~~or~~

86 (B) A person covered under paragraph (2) of this subsection, if any coverage is
 87 provided by the association of another state to that person; or

88 (C) A person who acquires rights to receive payments through a structured settlement
 89 factoring transaction, as such term is defined in 26 U.S.C. Section 5891(c)(3)(A) as
 90 such term existed on January 23, 2002, regardless of whether the transaction occurred
 91 before or after such date.

92 (5) This chapter is intended to provide coverage to a person who is a resident of this state
 93 and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if
 94 a person who would otherwise receive coverage under this chapter is provided coverage
 95 under the laws of any other state, the person shall not be provided coverage under this
 96 chapter. In determining the application of the provisions of this subsection in situations
 97 where a person could be covered by the association of more than one state, whether as
 98 an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in
 99 conjunction with other state laws to result in coverage by only one association.

100 (c) Except as otherwise provided in subsection (d) of this Code section, This this chapter
101 shall not provide coverage to:

102 (1) That portion or part of a policy or contract not guaranteed by ~~an~~ a member insurer,
103 or under which the risk is borne by the policy or contract owner;

104 (2) A policy or contract of reinsurance or any policy or contract or part thereof assumed
105 by the impaired or insolvent insurer under a contract of reinsurance, unless assumption
106 certificates have been issued pursuant to the reinsurance policy or contract;

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

111 (A) Averaged over the period of four years prior to the date on which the member
112 insurer becomes an impaired or insolvent insurer under this chapter, whichever is
113 earlier, exceeds the rate of interest determined by subtracting two percentage points
114 from Moody's Corporate Bond Yield Average averaged for that same four-year period
115 or for such lesser period if the policy or contract was issued less than four years before
116 the member insurer becomes an impaired or insolvent insurer under this chapter,
117 whichever is earlier; and

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

122 ~~(4) Any policy, contract, certificate, health care plan referred to in Chapter 20 of this~~
123 ~~title; prepaid legal services plan, as defined in Code Section 33-35-2, or health~~
124 ~~maintenance organization, as defined in Code Section 33-21-1;~~

125 (5) Any policy, contract, or certificate issued by a fraternal benefit society, as defined in
126 Code Section 33-15-1;

127 (6) Accident and sickness insurance as defined in Code Section 33-7-2 when written by
128 a property and casualty insurer as part of an automobile insurance contract;

129 (7) A portion of a policy or contract issued to a plan or program of an employer,
130 association, or other person to provide life, health, or annuity benefits to its employees,
131 members, or others, to the extent that the plan or program is self-funded or uninsured,
132 including, but not limited to, benefits payable by an employer, association, or other
133 person under:

134 (A) A multiple employer welfare arrangement as defined in 29 U.S.C.
135 Section 1002(40);

136 (B) A minimum premium group insurance plan;

- 137 (C) A stop-loss insurance policy; or
138 (D) An administrative services only contract;
139 (8) A portion of a policy or contract to the extent that it provides for:
140 (A) Dividends or experience rating credits;
141 (B) Voting rights; or
142 (C) Payment of any fees or allowances to any person, including the policy or contract
143 owner, in connection with the service to or administration of the policy or contract;
144 (9) A policy or contract issued in this state by a member insurer at a time when it was not
145 licensed or did not have a certificate of authority to issue the policy or contract in this
146 state;
147 (10) Any unallocated annuity contract issued to an employee benefit plan protected
148 under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal
149 Pension Benefit Guaranty Corporation has yet become liable to make any payments with
150 respect to the benefit plan;
151 (11) Any portion of any unallocated annuity contract which is not issued to or in
152 connection with a specific employee, union, or association of natural persons benefit plan
153 or a government lottery;
154 (12) A portion of a policy or contract to the extent that the assessments required by Code
155 Section 33-38-15 with respect to the policy or contract are preempted by federal or state
156 law;
157 (13) An obligation that does not arise under the express written terms of the policy or
158 contract issued by the member insurer to the enrollee, certificate holder, contract owner
159 or policy owner, including without limitation:
160 (A) Claims based on marketing materials;
161 (B) Claims based on side letters, riders, or other documents that were issued by the
162 member insurer without meeting applicable policy or contract form filing or approval
163 requirements;
164 (C) Misrepresentations of or regarding policy or contract benefits;
165 (D) Extra-contractual claims; or
166 (E) A claim for penalties or consequential or incidental damages;
167 (14) A contractual agreement that establishes the member insurer's obligations to provide
168 a book value accounting guaranty for defined contribution benefit plan participants by
169 reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in
170 each case is not an affiliate of the member insurer;
171 (15) A portion of a policy or contract to the extent it provides for interest or other
172 changes in value to be determined by the use of an index or other external reference
173 stated in the policy or contract, but which have not been credited to the policy or contract,

174 or as to which the policy or contract owner's rights are subject to forfeiture, as of the date
 175 the member insurer becomes an impaired or insolvent insurer under this chapter,
 176 whichever is earlier. If a policy's or contract's interest or changes in value are credited
 177 less frequently than annually, then for purposes of determining the values that have been
 178 credited and are not subject to forfeiture under this paragraph, the interest or change in
 179 value determined by using the procedures defined in the policy or contract will be
 180 credited as if the contractual date of crediting interest or changing values was the date of
 181 impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; ~~or~~
 182 (16) A policy or contract providing any hospital, medical, prescription drug, or other
 183 health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of
 184 Title 42 of the United States Code, commonly known as Medicare Part C & D,
 185 Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as
 186 Medicaid), or any regulations issued pursuant thereto; or
 187 (17) Structured settlement annuity benefits to which a payee or beneficiary has
 188 transferred his or her rights in a structured settlement factoring transaction, as such term
 189 is defined in 26 U.S.C. Section 5891(c)(3)(A) as such term existed on January 23, 2002,
 190 regardless of whether the transaction occurred before or after such date.
 191 (d) The exclusion from coverage referenced in paragraph (3) of subsection (c) of this Code
 192 section shall not apply to any portion of a policy or contract, including a rider, that provides
 193 long-term care for any other health insurance benefit.
 194 ~~(d)~~(e) The provisions of this Code section shall apply only to coverage the guaranty
 195 association Georgia Life and Health Insurance Guaranty Association provides in
 196 connection with any member insurer that is placed under an order of liquidation with a
 197 finding of insolvency on or after July 1, ~~2012~~ 2020."

198 **SECTION 3.**

199 Said chapter is further amended by revising Code Section 33-38-4, relating to definitions, as
 200 follows:

201 "33-38-4.

202 As used in this chapter, the term:

203 (1) 'Account' means any of the two accounts created under Code Section 33-38-5.

204 (2) 'Affiliate' means any person that directly, or indirectly through one or more
 205 intermediaries, controls, is controlled by, or is under common control with the person
 206 specified.

207 (3) 'Association' means the Georgia Life and Health Insurance Guaranty Association
 208 created under Code Section 33-38-5.

209 (4) 'Authorized assessment,' or 'authorized' when used in the context of assessments,
 210 means a resolution by the board of directors of the association has been passed whereby
 211 an assessment will be called immediately or in the future from member insurers for a
 212 specified amount. An assessment is authorized when the resolution is passed.

213 (5) 'Benefit plan' means a specific employee, union, or association of natural persons
 214 benefit plan.

215 (6) 'Called assessment,' or 'called' when used in the context of assessments, means that
 216 a notice has been issued by the association to member insurers requiring that an
 217 authorized assessment be paid within the time frame set forth within the notice. An
 218 authorized assessment becomes a called assessment when notice is mailed by the
 219 association to member insurers.

220 (7) 'Contractual obligation' means any obligation under a covered policy, contract, or
 221 certificate under a group policy or contract, or portion thereof for which coverage is
 222 provided under Code Section 33-38-2.

223 (8) 'Control' or 'controlled' means the possession, direct or indirect, of the power to direct
 224 or cause the direction of the management and policies of a person, whether through
 225 ownership of voting securities, by contract other than a commercial contract for goods
 226 or nonmanagement services, or otherwise.

227 (9) 'Covered contract' or 'covered policy' means a policy or contract or portion of a policy
 228 or contract for which coverage is provided under Code Section 33-38-2.

229 (10) 'Extra-contractual claims' shall include, for example, any claim not authorized by,
 230 or outside the scope of, the underlying policy or contract to include any claim based on
 231 bad faith, punitive or exemplary damages, treble damages, prejudgment or postjudgment
 232 interest, attorney's fees, or costs of litigation.

233 (11) 'Health benefit plan' means any hospital or medical expense policy or certificate,
 234 health maintenance organization subscriber contract, or any other similar health contract.

235 This term does not include:

236 (A) Accident only insurance;

237 (B) Credit insurance;

238 (C) Dental only insurance;

239 (D) Vision only insurance;

240 (E) Medicare supplement insurance;

241 (F) Benefits for long-term care, home health care, community based care, or any
 242 combination thereof;

243 (G) Disability income insurance;

244 (H) Coverage for on-site medical clinics; or

245 (I) Specified disease, hospital confinement indemnity, or limited benefit health
 246 insurance if the types of coverage do not provide coordination of benefits and are
 247 provided under separate policies or certificates.

248 (12) 'Health care corporation' means a corporation established in accordance with the
 249 provisions of Chapter 20 of Title 33 to administer one or more health care plans as
 250 defined in Code Section 33-20-3(4).

251 ~~(11)~~(13) 'Impaired insurer' means a member insurer which is not an insolvent insurer and
 252 is placed under an order of rehabilitation or conservation by a court of competent
 253 jurisdiction.

254 ~~(12)~~(14) 'Insolvent insurer' means a member insurer against which an order of liquidation
 255 containing a finding of insolvency has been entered by a court of competent jurisdiction.

256 ~~(13)~~(15) 'Member insurer' means any insurer, health maintenance organization, or health
 257 care corporation which is licensed or which holds a certificate of authority to transact in
 258 this state any kind of insurance, health care plan, or health maintenance organization
 259 business for which coverage is provided under Code Section 33-38-2 and includes any
 260 insurer, health care corporation, or health maintenance organization whose license or
 261 certificate of authority in this state may have been suspended, revoked, not renewed, or
 262 voluntarily withdrawn, but does not include:

263 ~~(A)~~ A for profit hospital or medical service corporation;

264 ~~(B)~~ A health care corporation;

265 ~~(C)~~ A health maintenance organization;

266 ~~(D)~~(A) A fraternal benefit society;

267 ~~(E)~~(B) A mandatory state pooling plan;

268 ~~(F)~~(C) A mutual assessment company or any entity that operates on an assessment
 269 basis;

270 ~~(G)~~(D) An insurance exchange;

271 ~~(H)~~(E) An organization that has a certificate or license limited to the issuance of
 272 charitable gift annuities under Code Sections 33-58-1 through 33-58-6; or

273 ~~(I)~~(F) Any entity similar to those described in subparagraphs (A) through ~~(H)~~(E) of this
 274 paragraph.

275 ~~(14)~~(16) 'Moody's Corporate Bond Yield Average' means the Monthly Average
 276 Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

277 ~~(15)~~(17) 'Owner' of a policy or contract, and 'policyholder,' 'policy owner,' and 'contract
 278 owner' mean the person who is identified as the legal owner under the terms of the policy
 279 or contract or who is otherwise vested with legal title to the policy or contract through a
 280 valid assignment completed in accordance with the terms of the policy or contract and
 281 properly recorded as the owner on the books of the member insurer. The terms 'owner,'

282 'contract owner,' 'policyholder,' and 'policy owner' shall not include persons with a mere
283 beneficial interest in a policy or contract.

284 ~~(16)~~(18) 'Person' means any individual, corporation, limited liability company,
285 partnership, association, governmental body or entity, or voluntary organization.

286 ~~(17)~~(19) 'Plan sponsor' means:

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

289 (B) The employee organization in the case of a benefit plan established or maintained
290 by an employee organization; or

291 (C) In a case of a benefit plan established or maintained by two or more employers or
292 jointly by one or more employers and one or more employee organizations, the
293 association, committee, joint board of trustees, or other similar group of representatives
294 of the parties who establish or maintain the benefit plan.

295 ~~(18)~~(20) 'Premiums' means amounts or considerations, by whatever name called,
296 received on covered policies or contracts, less returned premiums, considerations and
297 deposits thereon and less dividends and experience credits. The term 'premiums' shall not
298 include:

299 (A) Amounts or considerations received for policies or contracts or for the portions of
300 policies or contracts for which coverage is not provided under this chapter except that
301 assessable premium shall not be reduced on account of paragraph (3) of subsection (c)
302 of Code Section 33-38-2, relating to interest limitations, and paragraph (12) of Code
303 Section 33-38-7, relating to limitations with respect to one individual, one participant,
304 and one policy or contract owner;

305 (B) Premiums in excess of \$5 million on an unallocated annuity contract; or

306 (C) With respect to multiple nongroup policies of life insurance owned by one owner,
307 whether the policy or contract owner is an individual, firm, corporation, or other person,
308 and whether the persons insured are officers, managers, employees, or other persons,
309 premiums in excess of \$5 million with respect to these policies or contracts, regardless
310 of the number of policies or contracts held by the owner.

311 ~~(19)~~(21)(A) 'Principal place of business' of a plan sponsor or a person other than a
312 natural person means the single state in which the natural persons who establish policy
313 for the direction, control, and coordination of the operations of the entity as a whole
314 primarily exercise that function, determined by the association in its reasonable
315 judgment by considering the following factors:

316 (i) The state in which the primary executive and administrative headquarters of the
317 entity is located;

- 318 (ii) The state in which the principal office of the chief executive officer of the entity
 319 is located;
- 320 (iii) The state in which the board of directors, or similar governing person or persons,
 321 of the entity conducts the majority of its meetings;
- 322 (iv) The state in which the executive or management committee of the board of
 323 directors, or similar governing person or persons, of the entity conducts the majority
 324 of its meetings;
- 325 (v) The state from which the management of the overall operations of the entity is
 326 directed; and
- 327 (vi) In the case of a benefit plan sponsored by affiliated companies comprising a
 328 consolidated corporation, the state in which the holding company or controlling
 329 affiliate has its principal place of business as determined using the above factors.
- 330 However, in the case of a plan sponsor, if more than 50 percent of the participants in
 331 the benefit plan are employed in a single state, that state shall be deemed to be the
 332 principal place of business of the plan sponsor.
- 333 (B) The principal place of business of a plan sponsor of a benefit plan described in
 334 subparagraph (C) of paragraph ~~(17)~~(19) of this Code section shall be deemed to be the
 335 principal place of business of the association, committee, joint board of trustees, or
 336 other similar group of representatives of the parties who establish or maintain the
 337 benefit plan that, in lieu of a specific or clear designation of a principal place of
 338 business, shall be deemed to be the principal place of business of the employer or
 339 employee organization that has the largest investment in the benefit plan in question.
- 340 ~~(20)~~(22) 'Receivership court' means the court in the insolvent or impaired insurer's state
 341 having jurisdiction over the conservation, rehabilitation, or liquidation of the member
 342 insurer.
- 343 ~~(21)~~(23) 'Resident' means any person who resides in this state at the time a member
 344 insurer is determined to be an impaired or insolvent insurer and to whom contractual
 345 obligations are owed. A person may be a resident of only one state, which, in the case
 346 of a person other than a natural person, shall be its principal place of business. Citizens
 347 of the United States who are either residents of foreign countries or residents of United
 348 States possessions, territories, or protectorates that do not have an association similar to
 349 the association created by this chapter shall be deemed residents of the state of domicile
 350 of the member insurer that issued the policies or contracts.
- 351 ~~(22)~~(24) 'State' means a state, the District of Columbia, Puerto Rico, and a United States
 352 possession, territory, or protectorate.

353 ~~(23)~~(25) 'Structured settlement annuity' means an annuity purchased in order to fund
 354 periodic payments for a plaintiff or other claimant in payment for or with respect to
 355 personal injury suffered by the plaintiff or other claimant.

356 ~~(24)~~(26) 'Supplemental contract' means a written agreement entered into for the
 357 distribution of proceeds under a life, health, or annuity policy or contract.

358 ~~(25)~~(27) 'Unallocated annuity contract' means an annuity contract or group annuity
 359 certificate which is not issued to and owned by an individual, except to the extent of any
 360 annuity benefits guaranteed to an individual by an insurer under the contract or
 361 certificate."

362 **SECTION 4.**

363 Said chapter is further amended by revising Code Section 33-38-5, relating to creation,
 364 required membership, functions and powers, supervision of association, and accounts for
 365 administration and assessment, as follows:

366 "33-38-5.

367 (a) There is created a nonprofit, unincorporated association to be known as the Georgia
 368 Life and Health Insurance Guaranty Association. All member insurers shall be and remain
 369 members of the association as a condition of their authority to transact insurance, a health
 370 maintenance organization business, or a health care corporation business in this state. The
 371 association shall perform its functions under the plan of operation established and approved
 372 under Code Section 33-38-8 and shall exercise its powers through a board of directors
 373 established under Code Section 33-38-6.

374 (b) The association shall come under the immediate supervision of the Commissioner and
 375 shall be subject to the applicable provisions of the insurance laws of this state.

376 (c) For purposes of administration and assessment, the association shall maintain two
 377 accounts: (1) the health insurance account; and (2) the life insurance and annuity account.
 378 The life insurance and annuity account shall contain three subaccounts: (A) the life
 379 insurance account; (B) the annuity account; and (C) the unallocated annuity account.

380 (d) For purposes of assessment, supplemental contracts shall be covered under the account
 381 in which the basic policy is covered."

382 **SECTION 5.**

383 Said chapter is further amended by revising Code Section 33-38-6, relating to membership
 384 of the board of directors, vacancies, compensation, and reimbursement of expenses, as
 385 follows:

386 "33-38-6.

387 (a) The board of directors of the association shall consist of not less than ~~five~~ seven nor
 388 more than ~~nine~~ 11 member insurers serving terms as established in the plan of operation.
 389 The members of the board shall be selected by the Commissioner from a list provided to
 390 the Commissioner from the board. Vacancies on the board shall be filled for the remaining
 391 period of the term by a majority vote of the remaining board members, subject to the
 392 approval of the Commissioner.

393 (b) In approving selections of members to the board, the Commissioner shall consider,
 394 among other things, whether all member insurers are fairly represented.

395 (c) Members of the board may be reimbursed from the assets of the association for
 396 reasonable expenses incurred by them in their capacity as members of the board of
 397 directors, but members of the board shall not otherwise be compensated by the association
 398 for their services."

399 **SECTION 6.**

400 Said chapter is further amended by revising Code Section 33-38-7, relating to powers and
 401 duties of the association generally, as follows:

402 "33-38-7.

403 (a) In addition to the powers and duties enumerated elsewhere in this chapter, the
 404 association shall have the following powers and duties:

405 (1) If a member insurer is an impaired insurer, the association, subject to any conditions,
 406 other than those conditions which impair the contractual obligations of the impaired
 407 insurer, imposed by the association and approved by the Commissioner, may, in its
 408 discretion:

409 (A) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed,
 410 reissued, or reinsured, any or all of the covered policies or contracts of the impaired
 411 insurer; and

412 (B) Provide such moneys, pledges, loans, notes, guarantees, or other means as are
 413 proper to effectuate subparagraph (A) of this paragraph and assure payment of the
 414 contractual obligations of the impaired insurer pending action under subparagraph (A)
 415 of this paragraph; and

416 (2) If a member insurer is an insolvent insurer, the association shall, in its discretion,
 417 either:

418 (A)(i)(I) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed,
 419 assumed, reissued, or reinsured, the covered policies or contracts of the insolvent
 420 insurer; or

421 (II) Assure payment of the contractual obligations of the insolvent insurer; and

- 422 (ii) Provide moneys, pledges, loans, notes, guarantees, or other means as are
 423 reasonably necessary to discharge the association's duties; or
- 424 (B) Provide benefits and coverages in accordance with the following provisions:
- 425 (i) With respect to ~~life and health insurance~~ policies and ~~annuities~~ contracts, assure
 426 payment of benefits ~~for premiums identical to the premiums and benefits, except for~~
 427 ~~terms of conversion and renewability~~, that would have been payable under the
 428 policies or contracts of the insolvent insurer, for claims incurred:
- 429 (I) With respect to group policies and contracts, not later than the earlier of the next
 430 renewal date under those policies or contracts or 45 days, but in no event less
 431 than 30 days, after the date on which the association becomes obligated with respect
 432 to the policies and contracts; and
- 433 (II) With respect to nongroup policies, contracts, and annuities, not later than the
 434 earlier of the next renewal date, if any, under the policies or contracts or one year,
 435 but in no event less than 30 days, from the date on which the association becomes
 436 obligated with respect to the policies or contracts;
- 437 (ii) Make diligent efforts to provide all known insureds, enrollees, or annuitants, for
 438 nongroup policies and contracts, or group policy or contract owners with respect to
 439 group policies and contracts, 30 days' notice of the termination, pursuant to division
 440 (i) of this subparagraph, of the benefits provided;
- 441 (iii) With respect to nongroup ~~life and health insurance~~ policies and ~~annuities~~
 442 contracts covered by the association, make available to each known insured, enrollee,
 443 or annuitant, or owner if other than the insured or annuitant, and with respect to an
 444 individual formerly an insured, enrollee, or ~~formerly an~~ annuitant under a group
 445 policy or contract who is not eligible for replacement group coverage, make available
 446 substitute coverage on an individual basis in accordance with the provisions of
 447 division (iv) of this subparagraph, if the insureds, enrollees, or annuitants had a right
 448 under law or the terminated policy, contract, or annuity to convert coverage to
 449 individual coverage or to continue an individual policy, contract, or annuity in force
 450 until a specified age or for a specified time, during which the insurer, health
 451 maintenance organization, or health care corporation had no right unilaterally to make
 452 changes in any provision of the policy, contract, or annuity or had a right only to
 453 make changes in premium by class;
- 454 (iv) In providing the substitute coverage required under division (iii) of this
 455 subparagraph, the association may offer either to reissue the terminated coverage or
 456 to issue an alternative policy: or contract at actuarially justified rates, subject to the
 457 prior approval of the Commissioner. Alternative or reissued policies or contracts
 458 shall be offered without requiring evidence of insurability and shall not provide for

459 any waiting period or exclusion that would not have applied under the terminated
 460 policy or contract. The association may reinsure any alternative or reissued policy or
 461 contract;

462 (v)(I) Alternative policies or contracts adopted by the association shall be subject
 463 to the approval of the ~~domiciliary insurance commissioner~~ Commissioner. The
 464 association may adopt alternative policies or contracts of various types for future
 465 issuance without regard to any particular impairment or insolvency.

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

473 (III) Any alternative policy or contract issued by the association shall provide
 474 coverage of a type similar to that of the policy or contract issued by the impaired or
 475 insolvent insurer, as determined by the association;

476 (vi) If the association elects to reissue terminated coverage at a premium rate
 477 different from that charged under the terminated policy or contract, the premium shall
 478 be actuarially justified and set by the association in accordance with the amount of
 479 insurance or coverage provided and the age and class of risk, subject to prior approval
 480 of the ~~domiciliary insurance commissioner and the receivership court~~ Commissioner;

481 (vii) The association's obligations with respect to coverage under any policy or
 482 contract of the impaired or insolvent insurer or under any reissued or alternative
 483 policy or contract shall cease on the date the coverage, or policy, or contract is
 484 replaced by another similar policy or contract by the policy or contract owner, the
 485 insured, the enrollee, or the association; and

486 (viii) When proceeding under this subparagraph with respect to a policy or contract
 487 carrying guaranteed minimum interest rates, the association shall assure the payment
 488 or crediting of a rate of interest consistent with paragraph (3) of subsection (c) of
 489 Code Section 33-38-2;

490 (3) Nonpayment of premiums within 31 days after the date required under the terms of
 491 any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage
 492 shall terminate the association's obligations under the policy, contract or coverage under
 493 this chapter with respect to the policy, contract, or coverage, except with respect to any
 494 claims incurred or any net cash surrender value which may be due in accordance with the
 495 provisions of this chapter;

496 (4) Premiums due for coverage after entry of an order of liquidation of an insolvent
497 insurer shall belong to and be payable at the direction of the association. The association
498 shall be liable for unearned premiums due to policy or contract owners arising after the
499 entry of the order;

500 (5) The protection provided by this chapter shall not apply where any guaranty protection
501 is provided to residents of this state by the laws of the domiciliary state or jurisdiction of
502 the impaired or insolvent insurer other than this state;

503 (6) In carrying out its duties under paragraph (2) of this Code section, the association
504 may:

505 (A) Subject to approval by a court in this state, impose permanent policy or contract
506 liens in connection with a guarantee, assumption, or reinsurance agreement, if the
507 association finds that the amounts which can be assessed under this chapter are less
508 than the amounts needed to assure full and prompt performance of the association's
509 duties under this chapter, or that the economic or financial conditions as they affect
510 member insurers are sufficiently adverse to render the imposition of such permanent
511 policy or contract liens, to be in the public interest; and

512 (B) Subject to approval by a court in this state, impose temporary moratoriums or liens
513 on payments of cash values and policy loans, or any other right to withdraw funds held
514 in conjunction with policies or contracts, in addition to any contractual provisions for
515 deferral of cash or policy loan value. In addition, in the event of a temporary
516 moratorium or moratorium charge imposed by the receivership court on payment of
517 cash values or policy loans, or on any other right to withdraw funds held in conjunction
518 with policies or contracts, out of the assets of the impaired or insolvent insurer, the
519 association may defer the payment of cash values, policy loans, or other rights by the
520 association for the period of the moratorium or moratorium charge imposed by the
521 receivership court, except for claims covered by the association to be paid in
522 accordance with a hardship procedure established by the liquidator or rehabilitator and
523 approved by the receivership court;

524 (7) A deposit in this state, held pursuant to law or required by the Commissioner for the
525 benefit of creditors, including policy or contract owners, not turned over to the
526 domiciliary liquidator upon the entry of a final order of liquidation or order approving a
527 rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant
528 to Code Sections 33-3-8 through 33-3-10, shall be promptly paid to the association. The
529 association shall be entitled to retain a portion of any amount so paid to it equal to the
530 percentage determined by dividing the aggregate amount of policy owners or contract
531 owners' claims related to that insolvency for which the association has provided statutory
532 benefits by the aggregate amount of all policy or contract owners' claims in this state

533 related to that insolvency and shall remit to the domiciliary receiver the amount so paid
534 to the association less the amount retained pursuant to this paragraph. Any amount so
535 paid to the association and retained by it shall be treated as a distribution of estate assets
536 pursuant to applicable state receivership law dealing with early access disbursements.

537 (8) If the association fails to act within a reasonable period of time with respect to an
538 insolvent insurer, as provided in paragraph (2) of this Code section, the Commissioner
539 shall have the powers and duties of the association under this chapter with respect to the
540 insolvent insurers;

541 (9) Upon the Commissioner's request, the association may render assistance and advice
542 to the Commissioner concerning rehabilitation, payment of claims, continuance of
543 coverage, or the performance of other contractual obligations of any impaired or
544 insolvent insurer;

545 (10) The association shall have standing to appear or intervene before any court or
546 agency in this state with jurisdiction over an impaired or insolvent insurer concerning
547 which the association is or may become obligated under this chapter or with jurisdiction
548 over any person or property against which the association may have rights through
549 subrogation or otherwise. Such standing shall extend to all matters germane to the
550 powers and duties of the association, including but not limited to proposals for reinsuring,
551 reissuing, modifying, or guaranteeing the policies or contracts of the impaired or
552 insolvent insurer and the determination of the policies or contracts and contractual
553 obligations. The association shall also have the right to appear or intervene before a court
554 or agency in another state with jurisdiction over an impaired or insolvent insurer for
555 which the association is or may become obligated or with jurisdiction over any person or
556 property against whom the association may have rights through subrogation or otherwise;

557 (11)(A) Any person receiving benefits under this chapter shall be deemed to have
558 assigned the rights under, and any causes of action against any person for losses arising
559 under, resulting from, or otherwise relating to, the covered policy or contract to the
560 association to the extent of the benefits received because of this chapter, whether the
561 benefits are payments of or on account of contractual obligations, continuation of
562 coverage, or provision of substitute or alternative policies, contracts, or coverages. The
563 association may require an assignment to it of such rights and causes of action by any
564 enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a
565 condition precedent to the receipt of any rights or benefits conferred by this chapter
566 upon such person. The association shall be subrogated to these rights against the assets
567 of any impaired or insolvent insurer.

568 (B) The subrogation rights of the association under this paragraph shall have the same
 569 priority against the assets of the impaired or insolvent insurer as that possessed by the
 570 person entitled to receive benefits under this chapter.

571 (C) In addition to subparagraphs (A) and (B) of this paragraph, the association shall
 572 have all common law rights of subrogation and any other equitable or legal remedy that
 573 would have been available to the impaired or insolvent insurer or owner, beneficiary,
 574 enrollee, or payee of a policy or contract with respect to the policy or contracts.

575 (D) If subparagraphs (A) through (C) of this paragraph are invalid or ineffective with
 576 respect to any person or claim for any reason, the amount payable by the association
 577 with respect to the related covered obligations shall be reduced by the amount realized
 578 by any other person with respect to the person or claim that is attributable to the
 579 policies or contracts, or portion thereof, covered by the association.

580 (E) If the association has provided benefits with respect to a covered obligation and a
 581 person recovers amounts as to which the association has rights as described in this
 582 paragraph, the person shall pay to the association the portion of the recovery
 583 attributable to the policies or contracts, or portion thereof, covered by the association;

584 (12) The benefits that the association may become obligated to cover shall in no event
 585 exceed the lesser of:

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

588 (B) With respect to one life, regardless of the number of policies or contracts:

589 (i) The amount of \$300,000.00 in life insurance death benefits, but not more
 590 than \$100,000.00 in net cash surrender and net cash withdrawal values for life
 591 insurance;

592 (ii) ~~In~~ For health insurance benefits, \$300,000.00 for disability income insurance;
 593 \$300,000.00 for long-term care insurance; \$300,000.00 for health insurance other than
 594 disability income insurance as referenced above, long-term care insurance as
 595 referenced above, ~~and basic hospital, medical, and surgical insurance or major~~
 596 ~~medical insurance~~ or health benefit plans as referenced below, including any net cash
 597 surrender and net cash withdrawal values; and \$500,000.00 for ~~basic hospital,~~

598 ~~medical, and surgical insurance or major medical insurance;~~ health benefit plans; and

599 (iii) The amount of \$300,000.00 in the present value of annuity benefits, but not more
 600 than \$250,000.00 in net cash surrender and net cash withdrawal values for an annuity;

601 (C) With respect to each payee of a structured settlement annuity, or beneficiary or
 602 beneficiaries of the payee if deceased, \$300,000.00 in present value annuity benefits,
 603 in the aggregate, including net cash surrender and net cash withdrawal values, if any;

604 (D) However, in no event shall the association be obligated to cover more than:

605 (i) An aggregate of \$300,000.00 in benefits with respect to any one life under
 606 ~~subparagraph~~ subparagraphs (B) and (C) of this paragraph except with respect to
 607 benefits for ~~basic hospital, medical, and surgical insurance and major medical~~
 608 ~~insurance~~ health benefit plans under division (ii) of this subparagraph, in which case
 609 the aggregate liability of the association shall not exceed \$500,000.00 with respect to
 610 any one individual; or

611 (ii) With respect to one owner of multiple nongroup policies of life insurance,
 612 whether the policy or contract owner is an individual, firm, corporation, or other
 613 person, and whether the persons insured are officers, managers, employees, or other
 614 persons, more than \$5 million in benefits, regardless of the number of policies and
 615 contracts held by the owner;

616 (E) With respect to either one contract owner provided coverage under
 617 subparagraph (b)(2)(B) of Code Section 33-38-2 or one plan sponsor whose plans own
 618 directly or in trust one or more unallocated annuity contracts, \$5 million in benefits,
 619 regardless of the number of contracts with respect to the contract owner or plan
 620 sponsor. However, in the case where one or more unallocated annuity contracts are
 621 covered contracts under this chapter and are owned by a trust or other entity for the
 622 benefit of two or more plan sponsors, coverage shall be afforded by the association if
 623 the largest interest in the trust or entity owning the contract or contracts is held by a
 624 plan sponsor whose principal place of business is in this state and in no event shall the
 625 association be obligated to cover more than \$5 million in benefits with respect to all
 626 these unallocated contracts; ~~and~~

627 (F) The limitations set forth in this paragraph are limitations on the benefits for which
 628 the association is obligated before taking into account either its subrogation and
 629 assignment rights or the extent to which those benefits could be provided out of the
 630 assets of the impaired or insolvent insurer attributable to covered policies. The costs
 631 of the association's obligations under this chapter may be met by the use of assets
 632 attributable to covered policies or reimbursed to the association pursuant to its
 633 subrogation and assignment rights; and

634 (G) For purposes of this chapter, benefits provided by a long-term care rider to a life
 635 insurance policy or annuity contract shall be considered the same type of benefits as the
 636 base life insurance policy or annuity contract to which it relates.

637 (13) In performing its obligations to provide coverage under this Code section, the
 638 association shall not be required to guarantee, assume, reinsure, reissue, or perform, or
 639 cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual
 640 obligations of the insolvent or impaired insurer under a covered policy or contract that

- 641 ~~do~~ does not materially affect the economic values or economic benefits of the covered
 642 policy or contract;
- 643 (14) In addition to the rights and powers elsewhere in this chapter, the association may:
- 644 (A) Enter into such contracts as are necessary or proper to carry out the provisions and
 645 purposes of this chapter;
- 646 (B) Sue or be sued, including the right to seek a declaratory judgment in any superior
 647 court of this state as to uncertainties with respect to the payment of benefits under this
 648 Code section. The association may also take any legal actions necessary or proper for
 649 recovery of any unpaid assessments under Code Section 33-38-15 and may settle claims
 650 or potential claims against it;
- 651 (C) Borrow money to effect the purposes of this chapter. Any notes or other evidence
 652 of indebtedness of the association not in default shall be legal investments for domestic
 653 member insurers and may be carried as admitted assets;
- 654 (D) Employ or retain such persons as are necessary to handle the financial transactions
 655 of the association and to perform such other functions as become necessary or proper
 656 under this chapter;
- 657 (E) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary
 658 receiver to carry out the powers and duties of the association;
- 659 (F) Take such legal action as may be necessary to avoid payment of improper claims;
 660 and
- 661 (G) Exercise, for the purposes of this chapter and to the extent approved by the
 662 Commissioner, the powers of a domestic life insurer, health insurer, health maintenance
 663 organization or health ~~insurer~~ care corporation; but in no case may the association issue
 664 insurance policies or annuity contracts other than those issued to perform its obligations
 665 under this chapter;
- 666 (15) Organize itself as a corporation or in other legal form permitted by the laws of the
 667 state;
- 668 (16) Request information from a person seeking coverage from the association in order
 669 to aid the association in determining its obligations under this chapter with respect to the
 670 person, and the person shall promptly comply with the request;
- 671 (17) Unless prohibited by law, in accordance with the terms and conditions of the policy
 672 or contract, file for actuarially justified rate or premium increases for any policy or
 673 contract for which it provides coverage under this chapter;
- 674 ~~(17)~~(18) Take other necessary or appropriate action to discharge its duties and
 675 obligations under this chapter or to exercise its powers under this chapter;

676 ~~(18)~~(19) The association may join an organization of one or more other state associations
 677 of similar purposes, to further the purposes and administer the powers and duties of the
 678 association;

679 ~~(19)~~(20) With respect to covered policies for which the association becomes obligated
 680 after an entry of an order of liquidation, the association may elect to succeed to the rights
 681 of the insolvent insurer arising after the order of liquidation under any contract of
 682 reinsurance to which the insolvent insurer was a party, to the extent such contract
 683 provides coverage for losses occurring after the date of the order of liquidation. As a
 684 condition to making such election, the association must pay all unpaid premiums due
 685 under the contract for coverage relating to periods before and after the date on which the
 686 order of liquidation was entered;

687 ~~(20)~~(21) The board of directors shall have discretion and may exercise reasonable
 688 business judgment to determine the means by which the association is to provide the
 689 benefits of this chapter in an economical and efficient manner;

690 ~~(21)~~(22) Where the association has arranged or offered to provide the benefits of this
 691 chapter to a covered person under a plan or arrangement that fulfills the association's
 692 obligations under this chapter, the person shall not be entitled to benefits from the
 693 association in addition to or other than those provided under the plan or arrangement;

694 ~~(22)~~(23) Exclusive venue in any action by or against the association is in the Superior
 695 Court of DeKalb County. The association may, at its option, waive such venue as to
 696 specific actions. The association shall not be required to give an appeal bond in an appeal
 697 that relates to a cause of action arising under this chapter; and

698 ~~(23)~~(24) In carrying out its duties in connection with guaranteeing, assuming, reissuing,
 699 or reinsuring policies or contracts under paragraph (1) or (2) of this Code section, the
 700 association may, ~~subject to approval of the receivership court~~, issue substitute coverage
 701 for a policy or contract that provides an interest rate, crediting rate, or similar factor
 702 determined by use of an index or other external reference stated in the policy or contract
 703 employed in calculating returns or changes in value by issuing an alternative policy or
 704 contract in accordance with the following provisions:

705 (A) In lieu of the index or other external reference provided for in the original policy
 706 or contract, the alternative policy or contract provides for a fixed interest rate, payment
 707 of dividends with minimum guarantees, or a different method for calculating interest
 708 or changes in value;

709 (B) There is no requirement for evidence of insurability, waiting period, or other
 710 exclusion that would not have applied under the replaced policy or contract; and

711 (C) The alternative policy or contract is substantially similar to the replaced policy or
 712 contract in all other material terms.

713 (b) The provisions of this Code section shall apply only to coverage the ~~guaranty~~
 714 ~~association~~ Georgia Life and Health Insurance Guaranty Association provides in
 715 connection with any member insurer that is placed under an order of liquidation with a
 716 finding of insolvency on or after July 1, ~~2012~~ 2020."

717 **SECTION 7.**

718 Said chapter is further amended by revising Code Section 33-38-9, relating to delegation of
 719 powers and duties of the association, as follows:

720 "33-38-9.

721 The plan of operation described in Code Section 33-38-8 may provide that any or all
 722 powers and duties of the association, except those under subparagraph (a)(14)(C) ~~(C)~~ of
 723 ~~paragraph (14)~~ of Code Section 33-38-7 and Code Section 33-38-15, shall be delegated to
 724 a corporation, association, or other organization which performs or will perform functions
 725 similar to those of this association or its equivalent in two or more states. Such a
 726 corporation, association, or organization shall be reimbursed for any payments made on
 727 behalf of the association and shall be paid for its performance of any function of the
 728 association. A delegation under this Code section shall take effect only with the approval
 729 of both the board of directors and the Commissioner and may be made only to a
 730 corporation, association, or organization which extends protection not substantially less
 731 favorable and effective than that provided for by this chapter."

732 **SECTION 8.**

733 Said chapter is further amended by revising Code Section 33-38-10, relating to duties and
 734 powers of the Commissioner, as follows:

735 "33-38-10.

736 In addition to the duties and powers enumerated elsewhere in this chapter:

737 (1) The Commissioner shall:

738 (A) Upon request of the board of directors, provide the association with a statement of
 739 the premiums in the appropriate states for each member insurer; and

740 (B) When an impairment is declared and the amount of the impairment is determined,
 741 serve a demand upon the impaired insurer to make good the impairment within a
 742 reasonable time. Notice to the impaired insurer shall constitute notice to its
 743 shareholders, if any. The failure of the impaired insurer to comply promptly with such
 744 demand shall not excuse the association from the performance of its powers and duties
 745 under this chapter; and

746 (2) The Commissioner may suspend or revoke, after notice and hearing, the certificate
 747 of authority to transact ~~insurance~~ business in this state of any member insurer which fails
 748 to pay an assessment when due or fails to comply with the plan of operation."

749 **SECTION 9.**

750 Said chapter is further amended by revising Code Section 33-38-15, relating to assessments
 751 against member insurers, as follows:

752 "33-38-15.

753 (a) For the purpose of providing the funds necessary to carry out the powers and duties of
 754 the association, the board of directors shall assess the member insurers separately for the
 755 health account and for each subaccount of the life insurance and annuity account at such
 756 time and for such amounts as the board finds necessary. Assessment shall be due not less
 757 than 30 days after prior written notice to the member insurers.

758 (b) There shall be two classes of assessments, as follows:

759 (1) Class A assessments shall be authorized and called for the purpose of meeting
 760 administrative costs and legal and other general expenses not related to a particular
 761 impaired or insolvent insurer, and examinations conducted under the authority of
 762 subsection (c) of Code Section 33-38-16; and

763 (2) Class B assessments shall be authorized and called to the extent necessary to carry
 764 out the powers and duties of the association under Code Section 33-38-7 with regard to
 765 an impaired or insolvent insurer.

766 (c)(1) The amount of any Class A assessment shall be determined by the board of
 767 directors and may be made on a pro rata or non-pro rata basis. If a Class A assessment
 768 is made on a pro rata basis, the board may provide that it be credited against future
 769 Class B assessments. ~~An assessment for costs and expenses other than for examinations~~
 770 ~~which is made on a non-pro rata basis shall not exceed \$300.00 per company in any one~~
 771 ~~calendar year.~~ The amount of any Class B assessment except for assessments related to
 772 long-term care insurance, shall be allocated for assessment purposes among between the
 773 accounts or and among the subaccounts in subsection (c) of Code Section 33-38-5
 774 pursuant to an allocation formula which may be based on the premiums or reserves of the
 775 impaired or insolvent insurer or any other standard deemed by the board in its sole
 776 discretion as being fair and reasonable under the circumstances. The amount of the
 777 Class B assessment for long-term care insurance written by the impaired or insolvent
 778 insurer shall be allocated according to a method included in the plan of operation and
 779 approved by the Commissioner. Such method shall provide for 50 percent of the
 780 assessment to be allocated to accident and health member insurers and 50 percent to be
 781 allocated to life and annuity member insurers.

782 (2) Class B assessments against member insurers for each account or subaccount shall
783 be in the proportion that the premiums received on business in this state by each assessed
784 member insurer on policies or contracts covered by each account or subaccount for the
785 three most recent calendar years for which information is available preceding the year in
786 which the member insurer became impaired or insolvent, as the case may be, bears to
787 such premiums received on business in this state for such calendar years by all assessed
788 member insurers.

789 (3) Assessments for funds to meet the requirements of the association with respect to an
790 impaired or insolvent insurer shall not be authorized or called until necessary to
791 implement the purposes of this chapter. Classification of assessments under
792 subsection (b) of this Code section and computation of assessments under this subsection
793 shall be made with a reasonable degree of accuracy, recognizing that exact
794 determinations may not always be possible. The association shall notify each member
795 insurer of its anticipated pro rata share of an authorized assessment not yet called within
796 180 days after the assessment is authorized.

797 (d) The association may abate or defer in whole or in part the assessment of a member
798 insurer if, in the opinion of the board of directors, payment of the assessment would
799 endanger the ability of the member insurer to fulfill its contractual obligations. In the event
800 an assessment against a member insurer is abated or deferred in whole or in part, the
801 amount by which such assessment is abated or deferred may be assessed against the other
802 member insurers in a manner consistent with the basis for assessments set forth in this
803 Code section. Once the conditions that caused a deferral have been removed or rectified,
804 the member insurer shall pay all assessments that were deferred pursuant to a repayment
805 plan approved by the association.

806 (e)(1) The total of all assessments upon a member insurer for each account shall not in
807 any one calendar year exceed 2 percent of such member insurer's premiums received in
808 this state on the policies covered by the account during the calendar year preceding the
809 assessment. If the maximum assessment in any account, together with the other assets of
810 the association, does not provide in any one year in such account an amount sufficient to
811 carry out the responsibilities of the association, the necessary additional funds shall be
812 assessed as soon thereafter as permitted by this chapter.

813 (2) The total of all assessments upon a member insurer for each subaccount of the life
814 insurance and annuity account shall not in any one calendar year exceed 2 percent of such
815 insurer's premiums received in this state on the policies covered by the subaccount during
816 the calendar year preceding the assessment. If the maximum assessment for any
817 subaccount of the life insurance and annuity account in any one year does not provide an
818 amount sufficient to carry out the responsibilities of the association, then the board shall

819 assess the other subaccounts of the life insurance and annuity account for the necessary
820 additional amount up to the maximum assessment level provided in paragraph (1) of this
821 subsection.

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

830 (g) It shall be proper for any member insurer in determining its premium rates and policy
831 owner dividends as to any kind of insurance health maintenance organization business or
832 health care corporation business within the scope of this chapter to consider the amount
833 reasonably necessary to meet its assessment obligations under this chapter.

834 (h) The association shall issue to each member insurer paying an assessment under this
835 chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed
836 by the Commissioner for the amount of the assessment paid. All outstanding certificates
837 shall be of equal dignity and priority without reference to amounts or dates of issue. A
838 certificate of contribution may be shown by the member insurer in its financial statement
839 as an asset in such form, for such an amount and for such period of time, not to exceed five
840 years from the date of assessment, as the Commissioner may approve.

841 (i)(1) A member insurer that wishes to protest all or part of an assessment shall pay when
842 due the full amount of the assessment as set forth in the notice provided by the
843 association. The payment shall be available to meet association obligations during the
844 pendency of the protest or any subsequent appeal. Payment shall be accompanied by a
845 statement in writing that the payment is made under protest and setting forth a brief
846 statement of the grounds for the protest.

847 (2) Within 60 days following the payment of an assessment under protest by a member
848 insurer, the association shall notify the member insurer in writing of its determination
849 with respect to the protest unless the association notifies the member insurer that
850 additional time is required to resolve the issues raised by the protest.

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

855 (4) In the alternative to rendering a final decision with respect to a protest based on a
 856 question regarding the assessment base, the association may refer protests to the
 857 Commissioner for a final decision, with or without a recommendation from the
 858 association.

859 (5) If the protest or appeal on the assessment is upheld, the amount paid in error or
 860 excess shall be returned to the member insurer company. Interest on a refund due a
 861 protesting member insurer shall be paid at the rate actually earned by the association.

862 (j) The association may request information of member insurers in order to aid in the
 863 exercise of its power under this Code section, and member insurers shall promptly comply
 864 with a request."

865 **SECTION 10.**

866 Said chapter is further amended by revising Code Section 33-38-16, relating to reports and
 867 recommendations as to solvency of companies, and board may report information as to
 868 insolvency of member insurer, examinations of member insurers, and reports of insurer
 869 insolvencies, as follows:

870 "33-38-16.

871 (a) The board of directors may, upon majority vote, make reports and recommendations
 872 to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation,
 873 or conservation of any member insurer, or to the solvency of any company health
 874 maintenance organization, insurer, or health care corporation seeking to do an insurance
 875 business in this state. Such reports and recommendations shall not be considered public
 876 documents.

877 (b) The board of directors may, upon majority vote, notify the Commissioner of any
 878 information indicating any member insurer may be an impaired or insolvent insurer.

879 (c) The board of directors may, upon majority vote, request that the Commissioner order
 880 an examination of any member insurer which the board in good faith believes may be an
 881 impaired or insolvent insurer. Within 30 days of the receipt of such request, the
 882 Commissioner shall begin such examination. The examination may be conducted as a
 883 National Association of Insurance Commissioners' examination or may be conducted by
 884 such persons as the Commissioner designates. The cost of such examination shall be paid
 885 by the association, and the examination report shall be treated the same as other
 886 examination reports. In no event shall such examination report be released to the board of
 887 directors prior to its release to the public, but this shall not preclude the Commissioner
 888 from complying with subsection (a) of this Code section. The Commissioner shall notify
 889 the board of directors when the examination is completed. The request for an examination

890 shall be kept on file by the Commissioner, but it shall not be open to public inspection prior
891 to the release of the examination report to the public.

892 (d) The board of directors may, upon majority vote, make recommendations to the
893 Commissioner for the detection and prevention of member insurer insolvencies.

894 (e) The board of directors shall, at the conclusion of any insurer insolvency in which the
895 association was obligated to pay covered claims, prepare a report to the Commissioner
896 containing such information as it may have in its possession bearing on the history and
897 causes of such insolvency. The board shall cooperate with the board of directors of
898 guaranty associations in other states in preparing a report on the history and causes of
899 insolvency of a particular insurer and may adopt by reference any report prepared by such
900 other associations."

901 SECTION 11.

902 Said chapter is further amended by revising Code Section 33-38-17, relating to assessment
903 liability, association as creditor of insolvent or impaired insurer, distribution of insolvent
904 insurer's ownership rights, reimbursement of association from disbursement of marshaled
905 assets as available, and recovery of distributions to affiliates, as follows:

906 "33-38-17.

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

910 (b) For the purpose of carrying out its obligations under this chapter, the association shall
911 be deemed to be a creditor of the impaired or insolvent insurer to the extent of the assets
912 attributable to covered policies, reduced by any amounts to which the association is entitled
913 as subrogee pursuant to paragraph (11) of Code Section 33-38-7. The assets of the
914 impaired or insolvent insurer attributable to covered policies shall be used by the
915 association to continue the covered policies and pay the contractual obligations of the
916 impaired or insolvent insurer as required by this chapter. For purposes of this subsection,
917 that portion of the total assets of an impaired or insolvent insurer that is attributable to
918 covered policies or contracts shall be determined by using the same proportion as the
919 reserves that should have been established for such policies or contracts bears to the
920 reserves that should have been established for all policies of insurance or health benefit
921 plans written by the impaired or insolvent insurer.

922 (c) As a creditor of the impaired or insolvent insurer as established in subsection (b) of this
923 Code section and consistent with Code Section 33-37-33, the association and other similar
924 associations shall be entitled to receive a disbursement of assets out of the marshaled
925 assets, from time to time as the assets become available to reimburse it, as a credit against

926 contractual obligations under this chapter. If the liquidator has not, within 120 days of a
 927 final determination of insolvency of ~~an~~ a member insurer by the receivership court, made
 928 an application to the court for the approval of a proposal to disburse assets out of marshaled
 929 assets to guaranty associations having obligations because of the insolvency, then the
 930 association shall be entitled to make application to the receivership court for approval of
 931 its own proposal to disburse these assets.

932 (d)(1) Prior to the termination of any liquidation, rehabilitation, or conservation
 933 proceeding, the court may take into consideration the contributions of the respective
 934 parties, including the association, the shareholders, contract owners, certificate holders,
 935 enrollees, and policy owners of the insolvent insurer, and any other party with a bona fide
 936 interest, in making an equitable distribution of the ownership rights of such insolvent
 937 insurer. In such a determination, consideration shall be given to the welfare of the
 938 policyholders, contract owners, certificate holders, and enrollees of the continuing or
 939 successor member insurer.

940 (2) No distribution to stockholders of an impaired or insolvent insurer shall be made until
 941 and unless the total amount of valid claims of the association with interest thereon for
 942 funds expended in carrying out its powers and duties under Code Section 33-38-7, with
 943 respect to such member insurer, has been fully recovered by the association.

944 (3) No insurer that is subject to any delinquency proceedings, whether formal or
 945 informal, administrative or judicial, shall have any of its assets returned to the control of
 946 its shareholders or private management until all payments of or on account of the insurer's
 947 contractual obligations by all guaranty associations, along with all expenses thereof and
 948 interest on all such payments and expenses, shall have been repaid to the guaranty
 949 associations or a plan of repayment by the insurer shall have been approved by the
 950 guaranty association.

951 (e)(1) If an order for liquidation or rehabilitation of ~~an~~ a member insurer domiciled in
 952 this state has been entered, the receiver appointed under such order shall have a right on
 953 behalf of the member insurer to recover from any affiliate the amount of distributions,
 954 other than stock dividends paid by the member insurer on its capital stock, made at any
 955 time during the five years preceding the petition for liquidation or rehabilitation, subject
 956 to the limitations of this Code section.

957 (2) No such distribution shall be recoverable if the member insurer shows that the
 958 distribution was lawful and reasonable when paid and that the member insurer did not
 959 know and could not reasonably have known that the distribution might adversely affect
 960 the ability of the member insurer to fulfill its contractual obligations.

961 (3) Any person who was an affiliate that controlled the member insurer at the time the
 962 distributions were paid shall be liable to the extent of the distributions received. Any

963 person who was an affiliate that controlled the member insurer at the time the
 964 distributions were declared shall be liable to the extent of the distributions that would
 965 have been received if such distributions had been paid immediately. Whenever two
 966 persons are liable with respect to the same distribution, they shall be jointly and severally
 967 liable.

968 (4) The maximum amount recoverable under this subsection shall be the amount needed,
 969 in excess of all other available assets of the insolvent insurer, to pay the contractual
 970 obligations of the insolvent insurer.

971 (5) Whenever any person liable under paragraph (3) of this subsection is insolvent, all
 972 affiliates that controlled it at the time the distribution was paid shall be jointly and
 973 severally liable for any resulting deficiency in the amount recovered from the insolvent
 974 affiliate."

975 **SECTION 12.**

976 Said chapter is further amended by revising Code Section 33-38-21, relating to references
 977 to the association in advertisements for insurance, as follows:

978 "33-38-21.

979 (a) No person, including ~~an~~ a member insurer or agent or affiliate of ~~an~~ a member insurer,
 980 shall make, publish, disseminate, circulate, or place before the public or cause directly or
 981 indirectly to be made, published, disseminated, circulated, or placed before the public, in
 982 any newspaper, magazine, or other publication; in the form of a notice, circular, pamphlet,
 983 letter, or poster; over any radio station or television station; or in any other way, any
 984 advertisement, announcement, or statement which uses the existence of the association for
 985 the purposes of sales, solicitation, or inducement to purchase any form of insurance or
 986 other coverage covered by this chapter. This Code section shall not apply to the
 987 association or any other entity which does not sell or solicit insurance or coverage provided
 988 by a health maintenance organization or a health care corporation.

989 (b) Any person who violates subsection (a) of this Code section may, after notice and
 990 hearing and upon order of the Commissioner, be subject to one or more of the following:

991 (1) A monetary penalty of not more than \$1,000.00 for each act or violation, but not to
 992 exceed an aggregate penalty of \$10,000.00; or

993 (2) Suspension or revocation of his or her license or certificate of authority."

994 **SECTION 13.**

995 Said chapter is further amended by revising Code Section 33-38-22, relating to premium tax
 996 liability offsets and refunds offset against taxes, as follows:

997 "33-38-22.

998 (a) A member insurer may offset against its premium tax liability to this state an
999 assessment described in Code Section 33-38-15 to the extent of 20 percent of the amount
1000 of such assessment for each of the five calendar years following the year in which such
1001 assessment was paid. In the event a member insurer should cease doing business, all
1002 uncredited assessments may be credited against its premium tax liability for the year it
1003 ceases doing business.

1004 (b) A member insurer that is exempt from taxes referenced in subsection (a) of this Code
1005 section may recoup its assessments by a surcharge on its premiums in a sum reasonably
1006 calculated to recoup the assessments over a reasonable period of time, as approved by the
1007 Commissioner. Amounts recouped shall not be considered premiums for any other
1008 purpose, including the computation of gross premium tax, the medical loss ratio, or agent
1009 commission. If a member insurer collects excess surcharges, the insurer shall remit the
1010 excess amount to the association, and the excess amount shall be applied to reduce future
1011 assessments in the appropriate account.

1012 ~~(b)~~(c) Any sums which are acquired by refund, pursuant to subsection (f) of Code
1013 Section 33-38-15, from the association by member insurers and which have theretofore
1014 been offset against premium taxes as provided in subsection (a) of this Code section shall
1015 be paid by such member insurers to this state in such manner as the Commissioner may
1016 require. The association shall notify the Commissioner that such refunds have been made."

1017

SECTION 14.

1018 All laws and parts of laws in conflict with this Act are repealed.