WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Committee Substitute

for

Senate Bill 493

BY SENATOR AZINGER

[Originating in the Committee on Banking and

Insurance; Reported on February 20, 2018]

1 A BILL to repeal §33-26B-1, §33-26B-2, §33-26B-3, §33-26B-4, §33-26B-5, §33-26B-6, §33-26B-
2 7, §33-26B-8, §33-26B-9, §33-26B-10, §33-26B-11, §33-26B-12, §33-26B-13, §33-26B-
3 14, §33-26B-15, and §33-26B-16 of the Code of West Virginia, 1931, as amended; and to
4 amend and reenact §33-26A-2, §33-26A-3, §33-26A-5, §33-26A-6, §33-26A-7, §33-26A-
5 8, §33-26A-9, §33-26A-11, §33-26A-12, §33-26A-14, and §33-26A-19 of said code, all
6 relating to guaranty associations; repealing West Virginia Health Maintenance
7 Organization Guaranty Association Act; and updating West Virginia Life and Health
8 Insurance Guaranty Association Act to maintain consistency with National Association of
9 Insurance Commissioners Life and Health Insurance Guaranty Association Model Act.

Be it enacted by the Legislature of West Virginia:

ARTICLE 26B. WEST VIRGINIA HEALTH MAINTENANCE ORGANIZATION GUARANTY ASSOCIATION.

§33-26B-1. Short title.

1 [Repealed.]

§33-26B-2. Purpose.

1 [Repealed.]

§33-26B-3. Scope.

1 [Repealed.]

§33-26B-4. Construction.

1 [Repealed.]

§33-26B-5. Definitions.

1 [Repealed.]

§33-26B-6. Creation of association.

1 [Repealed.]

§33-26B-7. Board of directors.

1 [Repealed.]

§33-26B-8. Powers and duties of the association.

1 [Repealed.]

§33-26B-9. Assessments.

1 [Repealed.]

§33-26B-10. Plan of operation.

1 [Repealed.]

§33-26B-11. Powers and duties of the commissioner.

1 [Repealed.]

§33-26B-12. Records.

1 [Repealed.]

§33-26B-13. Annual report of the association.

1 [Repealed.]

§33-26B-14. Tax exemptions.

1 [Repealed.]

§33-26B-15. Immunity.

1 [Repealed.]

§33-26B-16. Prohibited advertisements.

1 [Repealed.]

ARTICLE 26A. WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.

§33-26A-2. Purpose of article and association of insurers.

1 (a) The purpose of this article is to protect, subject to certain limitations, the persons
2 specified in §33-26A-3(a) of this code against failure in the performance of contractual obligations,
3 under life, ~~and~~ health, ~~insurance policies~~ and annuity <u>policies, plans, or</u> contracts specified in §33-

26A-3(b) of this code, because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

(b) To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited ~~herein~~ by this article, and members of the association are subject to assessment to provide funds to carry out the purpose of this article.

§33-26A-3. Scope of article; policies and contracts covered; exclusions; extent of liability.

(a) This article shall provide coverage for the policies and contracts specified in §33-26A-3(b) of this code:

(1) 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 §33-26A-3(a)(2) of this code~~: *Provided*, That the provisions of this subdivision shall not apply to nonresident certificate holders under group policies or contracts~~.

(2) To persons who are owners of or certificate holders or enrollees under ~~such~~ the policies or contracts, other than unallocated annuity contracts and structured settlement annuities, and in each case who:

(A) Are residents of this state; or

(B) Are not residents of this state, but only under all of the following conditions:

(i) The member insurer that issued the policies or contracts is domiciled in this state;

(ii) The states in which the persons reside have associations similar to the association created by this article; and

(iii) The persons are not eligible for coverage by an association in any other state because the insurer or the health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(3) For unallocated annuity contracts specified in ~~subdivisions (1) and (2), subsection (b) of this section~~ §33-26A-3(b) of this code, §33-26A-3(a)(1) and §33-26A-3(a)(2) of this code shall

21 not apply, and this article shall, except as provided in §33-26A-3(a)(5) and §33-26A-3(a)(6) of this
22 code, provide coverage to:
23 (A) Persons who are the owners of the unallocated annuity contracts if the contracts are
24 issued to or in connection with a specific benefit plan whose plan sponsor has its principal place
25 of business in this state; and
26 (B) Persons who are owners of unallocated annuity contracts issued to or in connection
27 with government lotteries if the owners are residents.
28 (4) For structured settlement annuities specified in ~~subdivisions (1) and (2), subsection (b)~~
29 ~~of this section~~ §33-26A-3(b) of this code, §33-26A-3(a)(1) and §33-26A-3(a)(2) of this code shall
30 not apply, and this article shall, except as provided in §33-26A-3(a)(5) and §33-26A-3(a)(6) of this
31 code, provide coverage to a person who is a payee under a structured settlement annuity, or
32 beneficiary of a payee if the payee is deceased, if the payee:
33 (A) Is a resident, regardless of where the contract owner resides; or
34 (B) Is not a resident, but only under both of the following conditions:
35 (i) (I) The contract owner of the structured settlement annuity is a resident; or
36 (II) The contract owner of the structured settlement annuity is not a resident, but the insurer
37 that issued the structured settlement annuity is domiciled in this state and the state in which the
38 contract owner resides has an association similar to the association created by this article; and
39 (ii) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the
40 association of the state in which the payee or contract owner resides.
41 (5) This article shall not provide coverage to:
42 (A) A person who is a payee or beneficiary of a contract owner resident of this state, if the
43 payee or beneficiary is afforded any coverage by the association of another state; or
44 (B) A person covered under §33-26A-3(a)(3) of this code, if any coverage is provided by
45 the association of another state to the person; or
46 (C) A person who acquires rights to receive payments through a structured settlement

47 factoring transaction as defined in 26 U.S.C. § 5891, regardless of whether the transaction
48 occurred before or after 26 U.S.C. § 5891 became effective.

49 (6) This article is intended to provide coverage to a person who is a resident of this state
50 and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person
51 who would otherwise receive coverage under this article is provided coverage under the laws of
52 any other state, the person shall not be provided coverage under this article. In determining the
53 application of the provisions of this subdivision in situations where a person could be covered by
54 the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or
55 assignee, this article shall be construed in conjunction with other state laws to result in coverage
56 by only one association.

57 (b) Coverage ~~as~~ provided by this article shall be as follows:

58 (1) This article shall provide coverage to the persons specified in §33-26A-3(a) of this code
59 for policies or contracts of direct, nongroup life insurance, health insurance (which for the
60 purposes of this article includes health maintenance organization subscriber contracts and
61 certificates), ~~and annuity policies or contracts, for any supplemental policies to the foregoing~~ or
62 annuities, and supplemental contracts to any of these, for certificates under direct group policies
63 and contracts, and for unallocated annuity contracts issued by member insurers, except as limited
64 by this article. Annuity contracts and certificates under group annuity contracts include but are not
65 limited to guaranteed investment contracts, deposit administration contracts, unallocated funding
66 agreements, allocated funding agreements, structured settlement annuities, annuities issued in
67 connection with government lotteries, and any immediate or deferred annuity contracts.

68 (2) ~~This~~ Except as otherwise provided in §33-26A-3(b)(3) of this code, this article shall not
69 provide coverage for:

70 (A) A portion of a policy or contract not guaranteed by the member insurer, or under which
71 the risk is borne by the policy or contract owner;

72 (B) A policy or contract of reinsurance, unless assumption certificates have been issued

73 pursuant to the reinsurance policy or contract;

74 (C) A portion of a policy or contract to the extent that the rate of interest on which it is

75 based, or the interest rate, crediting rate, or similar factor determined by use of an index or other

76 external reference stated in the policy or contract employed in calculating returns or changes in

77 value:

78 (i) Averaged over the period of four years prior to the date on which the member insurer

79 becomes an impaired or insolvent insurer under this article, whichever is earlier, exceeds ~~a~~ the

80 rate of interest determined by subtracting two percentage points from Moody's Corporate Bond

81 Yield Average averaged for that same four-year period or for such lesser period if the policy or

82 contract was issued less than four years before the member insurer becomes an impaired or

83 insolvent insurer under this article, whichever is earlier; and

84 (ii) On and after the date on which the member insurer becomes an impaired or insolvent

85 insurer under this article, whichever is earlier, exceeds the rate of interest determined by

86 subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently

87 available;

88 (D) A portion of a policy or contract issued to a plan or program of an employer,

89 association, or other person to provide life, health, or annuity benefits to its employees, members,

90 or others, to the extent that the plan or program is self-funded or uninsured, including but not

91 limited to, benefits payable by an employer, association, or other person under:

92 (i) A multiple employer welfare arrangement as defined in section 514 of the Employee

93 Retirement Income Security Act of 1974, 29 U.S.C. §1144, as amended;

94 (ii) A minimum premium group insurance plan;

95 (iii) A stop-loss group insurance plan; or

96 (iv) An administrative services only contract;

97 (E) A portion of a policy or contract to the extent that it provides for: ~~dividends~~

98 (i) Dividends or experience rating credits; ~~voting~~

99 (ii) Voting rights; or ~~payment~~

100 (iii) Payment of any fees or allowances to any person, including the policy or contract
101 owner, in connection with the service to or administration of the policy or contract;

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

104 (G) An unallocated annuity contract issued to ~~an employee~~ or in connection with a benefit
105 plan protected under the federal pension benefit guaranty corporation, regardless of whether the
106 federal pension benefit guaranty corporation has yet become liable to make any payments with
107 respect to the benefit plan; ~~and~~

108 (H) A portion of any unallocated annuity contract ~~which~~ that is not issued to or in
109 connection with a specific employee, union, or association of natural persons benefit plan or a
110 government lottery;

111 (I) A portion of a policy or contract to the extent that the assessments required by §33-
112 26A-9 of this code with respect to the policy or contract are preempted by federal or state law;

113 (J) An obligation that does not arise under the express written terms of the policy or
114 contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy
115 owner, including without limitation:

116 (i) Claims based on marketing materials;

117 (ii) Claims based on side letters, riders, or other documents that were issued by the
118 member insurer without meeting applicable policy or contract form filing or approval requirements;

119 (iii) Misrepresentations of or regarding policy or contract benefits;

120 (iv) Extra-contractual claims; or

121 (v) A claim for penalties or consequential or incidental damages;

122 (K) A contractual agreement that establishes the member insurer's obligations to provide
123 a book value accounting guaranty for defined contribution benefit plan participants by reference
124 to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not

125 an affiliate of the member insurer;

126 (L) A portion of a policy or contract to the extent it provides for interest or other changes
127 in value to be determined by the use of an index or other external reference stated in the policy
128 or contract, but which have not been credited to the policy or contract, or as to which the policy
129 or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an
130 impaired or insolvent insurer under this article, whichever is earlier. If a policy's or contract's
131 interest or changes in value are credited less frequently than annually, then for purposes of
132 determining the values that have been credited and are not subject to forfeiture, the interest or
133 change in value determined by using the procedures defined in the policy or contract will be
134 credited as if the contractual date of crediting interest or changing values was the date of
135 impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

136 (M) A policy or contract providing any hospital, medical, prescription drug, or other health
137 care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United
138 States Code (commonly known as Medicare Part C & D), or Subchapter XIX, Chapter 7 of Title
139 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant
140 thereto; or

141 (N) Structured settlement annuity benefits to which a payee (or beneficiary) has
142 transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C.
143 § 5891, regardless of whether the transaction occurred before or after that section became
144 effective.

145 (3) The exclusion from coverage referenced in §33-26A-3(b)(2)(C) of this code shall not
146 apply to any portion of a policy or contract, including a rider, that provides long-term care or any
147 other health insurance benefits.

148 (c) The benefits that the association may become liable for shall in no event exceed the
149 lesser of:

150 (1) The contractual obligations for which the member insurer is liable or would have been

151 liable if it were not an impaired or insolvent insurer; or

152 (2) (A) With respect to ~~any~~ one life, regardless of the number of policies or contracts:

153 (i) $300,000 in life insurance death benefits, but no more than $100,000 in net cash

154 surrender and net cash withdrawal values for life insurance;

155 (ii) ~~In~~ For health insurance benefits:

156 (I) $100,000 for coverages not defined as disability income insurance or ~~basic hospital,~~

157 ~~medical and surgical insurance or major medical insurance~~ health benefit plans or long-term care

158 insurance as defined in §33-15A-4 of this code, including any net cash surrender and net cash

159 withdrawal values;

160 (II) $300,000 for disability income insurance, and $300,000 for long-term care insurance

161 as defined in §33-15A-4 of this code;

162 (III) $500,000 for ~~basic hospital, medical and surgical insurance or major medical~~

163 ~~insurance; or~~ health benefit plans;

164 (iii) $250,000 in the present value of annuity benefits, including net cash surrender and

165 net cash withdrawal values; or

166 (B) With respect to each individual participating in a governmental retirement plan

167 established under section 401, 403(b), or 457 of the United States Internal Revenue Code

168 covered by an unallocated annuity contract or the beneficiaries of each such individual if

169 deceased, in the aggregate, $250,000 in present value annuity benefits, including net cash

170 surrender and net cash withdrawal values;

171 (C) With respect to each payee of a structured settlement annuity, or beneficiary or

172 beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the

173 aggregate, including net cash surrender and net cash withdrawal ~~value~~ values, if any;

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

175 (i) An aggregate of $300,000 in benefits with respect to any one life under §33-26A-

176 3(c)(2)(A), §33-26A-3(c)(2)(B), or §33-26A-3(c)(2)(C) of this code except with respect to benefits

177 for ~~basic hospital, medical and surgical insurance and major medical insurance~~ health benefit
178 plans under §33-26A-3(c)(2)(A)(ii) of this code, in which case the aggregate liability of the
179 association shall not exceed $500,000 with respect to any one individual; or
180 (ii) With respect to one owner of multiple nongroup policies of life insurance, whether the
181 policy or contract owner is an individual, firm, corporation, or other person, and whether the
182 persons insured are officers, managers, employees, or other persons, more than $5 million in
183 benefits, regardless of the number of policies and contracts held by the owner.
184 (E) With respect to either one contract owner provided coverage under §33-26A-3(a)(3)(B)
185 of this code, or one plan sponsor whose plans own directly or in trust one or more unallocated
186 annuity contracts not included in §33-26A-3(c)(2)(B) of this code, $5 million in benefits,
187 irrespective of the number of contracts with respect to the contract owner or plan sponsor.
188 However, in the case where one or more unallocated annuity contracts are covered contracts
189 under this article and are owned by a trust or other entity for the benefit of two or more plan
190 sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity
191 owning the contract or contracts is held by a plan sponsor whose principal place of business is in
192 this state. In no event shall the association be obligated to cover more than $5 million in benefits
193 with respect to all of these unallocated contracts.
194 (F) The limitations set forth in this subsection are limitations on the benefits for which the
195 association is obligated before taking into account either its subrogation and assignment rights or
196 the extent to which those benefits could be provided out of the assets of the impaired or insolvent
197 insurer attributable to covered policies. The costs of the association's obligations under this article
198 may be met by the use of assets attributable to covered policies or reimbursed to the association
199 pursuant to its subrogation and assignment rights.
200 (G) For purposes of this article, benefits provided by a long-term care rider to a life
201 insurance policy or annuity contract shall be considered the same type of benefits as the base life
202 insurance policy or annuity contract to which it relates.

203 (d) In performing its obligations to provide coverage under §33-26A-8 of this code, the
204 association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to
205 be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the
206 insolvent or impaired insurer under a covered policy or contract that do not materially affect the
207 economic values or economic benefits of the covered policy or contract.

§33-26A-5. Definitions.

1 As used in this article:

2 (1) "Account" means either of the two accounts created under §33-26A-6 of this code.

3 (2) "Association" means the West Virginia Life and Health Insurance Guaranty Association
4 created under §33-26A-6 of this code.

5 (3) "Authorized assessment" or the term "authorized" when used in the context of
6 assessments means a resolution by the board of directors has been passed whereby an
7 assessment will be called immediately or in the future from member insurers for a specified
8 amount. An assessment is authorized when the resolution is passed.

9 (4) "Basic hospital, medical and surgical insurance or major medical insurance" means
10 accident and sickness insurance subject to the provisions of articles fifteen and sixteen of this
11 chapter and benefits provided by articles twenty-four and twenty-five of this chapter, but excludes
12 any accident and sickness insurance in which the medical care is secondary or incidental to other
13 benefits and also excludes insurance included within the definition of excluded benefits set forth
14 in subsection (f), section one-a, article sixteen of this chapter

15 (5) (4) "Benefit plan" means a specific employee, union, or association of natural persons
16 benefit plan.

17 (6) (5) "Called assessment" or the term "called" when used in the context of assessments
18 means that a notice has been issued by the association to member insurers requiring that an
19 authorized assessment be paid within the time frame set forth within the notice. An authorized

20 assessment becomes a called assessment when notice is mailed by the association to member
21 insurers.

22 ~~(7)~~ (6) "Commissioner" means the ~~Commissioner of Insurance of this state~~ Insurance
23 Commissioner of West Virginia.

24 ~~(8)~~ (7) "Contractual obligation" means any obligation under a policy or contract or
25 certificate under a group policy or contract, or portion thereof for which coverage is provided under
26 §33-26A-3 of this code.

27 ~~(9)~~ (8) "Covered contract" or "covered policy" means any policy or contract within the scope
28 of this article under §33-26A-3 of this code.

29 ~~(10)~~ (9) "Extra-contractual claims" shall include, for example, claims ~~such as those~~ relating
30 to bad faith in the payment of claims, punitive, or exemplary damages or attorneys' fees and costs.

31 (10) "Health benefit plan" means any hospital or medical expense policy or certificate
32 subject to §33-15-1 *et seq.* or §33-16-1 *et seq.* of this code and benefits provided subject to §33-
33 24-1 *et seq.* or §33-25-1 *et seq.* of this code, or health maintenance organization subscriber
34 contract or any other similar health contract subject to the provisions of §33-25A-1 *et seq.* of this
35 code. "Health benefit plan" does not include:

36 (i) Accident only insurance;

37 (ii) Credit insurance;

38 (iii) Dental only insurance;

39 (iv) Vision only insurance;

40 (v) Medicare Supplement insurance;

41 (vi) Benefits for long-term care, home health care, community-based care, or any
42 combination thereof;

43 (vii) Disability income insurance;

44 (viii) Coverage for on-site medical clinics; or

45 (ix) Specified disease, hospital confinement indemnity, or limited benefit health insurance
46 if the types of coverage do not provide coordination of benefits and are provided under separate
47 policies or certificates.

48 (11) "Impaired insurer" means a member insurer which, after the effective date of this
49 article, is not an insolvent insurer, and: (1) Is deemed by the commissioner to be potentially unable
50 to fulfill its contractual obligations: or (2) is placed under an order of rehabilitation or conservation
51 by a court of competent jurisdiction.

52 (12) "Insolvent insurer" means a member insurer which, after the effective date of this
53 article, is placed under an order of liquidation by a court of competent jurisdiction with a finding of
54 insolvency.

55 (13) "Member insurer" means any insurer or health maintenance organization licensed or
56 which holds a certificate of authority to transact in this state any kind of insurance or health
57 maintenance organization business for which coverage is provided under §33-26A-3 of this code,
58 and includes an insurer or health maintenance organization whose license or certificate of
59 authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn,
60 and includes nonprofit service corporations as defined in §33-24-1 *et seq.* of this code and health
61 care corporations as defined in §33-25-1 *et seq.* of this code, but does not include:

62 ~~(A) A health maintenance organization~~

63 ~~(B)~~(A) A fraternal benefit society;

64 ~~(C)~~ (B) A mandatory state pooling plan;

65 ~~(D)~~ (C) A mutual assessment company or any entity that operates on an assessment
66 basis;

67 ~~(E)~~ (D) An insurance exchange;

68 ~~(F)~~ (E) An organization which has a certificate or license limited to the issuance of
69 charitable gift annuities under §33-13B-1 *et seq.* of this code; or

70 ~~(G)~~ (F) Any entity similar to any of the above.

71 (14) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as
72 published by Moody's Investors Service, Inc., or any successor thereto.
73 (15) "Owner" of a policy or contract and "policyholder", "policy owner", and "contract
74 owner" mean the person who is identified as the legal owner under the terms of the policy or
75 contract or who is otherwise vested with legal title to the policy or contract through a valid
76 assignment completed in accordance with the terms of the policy or contract and properly
77 recorded as the owner on the books of the member insurer. The terms "owner", "contract owner",
78 "policyholder", and "policy owner" do not include persons with a mere beneficial interest in a policy
79 or contract.
80 (16) "Person" means any individual, corporation, limited liability company, partnership,
81 association, or voluntary organization.
82 (17) "Plan sponsor" means:
83 (A) The employer in the case of a benefit plan established or maintained by a single
84 employer;
85 (B) The employee organization in the case of a benefit plan established or maintained by
86 an employee organization; or
87 (C) In a case of a benefit plan established or maintained by two or more employers or
88 jointly by one or more employers and one or more employee organizations, the association,
89 committee, joint board of trustees, or other similar group of representatives of the parties who
90 establish or maintain the benefit plan.
91 (18) "Premiums" means amounts or considerations (by whatever name called) received
92 on covered policies or contracts less premiums, considerations, and deposits ~~returned thereon~~,
93 and less dividends and experience credits thereon. "Premiums" does not include ~~any~~ amounts or
94 considerations received for ~~any~~ policies or contracts or for the portions of ~~any~~ policies or contracts
95 for which coverage is not provided under §33-26A-3(b) of this code, except that assessable
96 premium shall not be reduced on account of §33-26A-3(b)(2)(C) of this code relating to interest

97 limitations and §33-26A-3(c)(2) of this code relating to limitations with respect to any one
98 individual, ~~any~~ one participant, and ~~any~~ one <u>policy or</u> contract owner. Premiums shall not include:
99 (A) Premiums in excess of $5 million on any unallocated annuity contract not issued under
100 a government retirement plan <u>or its trustee</u> established under sections 401, 403(b), or 457 of the
101 United States Internal Revenue Code; or
102 (B) With respect to multiple nongroup policies of life insurance owned by one owner,
103 whether the policy <u>or contract</u> owner is an individual, firm, corporation, or other person, and
104 whether the persons insured are officers, managers, employees, or other persons, premiums in
105 excess of $5 million with respect to these policies or contracts, regardless of the number of
106 policies or contracts held by the owner.
107 (19) (A) "Principal place of business" of a plan sponsor or a person other than a natural
108 person means the single state in which the natural persons who establish policy for the direction,
109 control, and coordination of the operations of the entity as a whole primarily exercise that function,
110 determined by the association in its reasonable judgment by considering the following factors:
111 (i) The state in which the primary executive and administrative headquarters of the entity
112 is located;
113 (ii) The state in which the principal office of the chief executive officer of the entity is
114 located;
115 (iii) The state in which the board of directors (or similar governing person or persons) of
116 the entity conducts the majority of its meetings;
117 (iv) The state in which the executive or management committee of the board of directors
118 (or similar governing person or persons) of the entity conducts the majority of its meetings; <u>and</u>
119 (v) The state from which the management of the overall operations of the entity is directed;
120 (vi) In the case of a benefit plan sponsored by affiliated companies comprising a
121 consolidated corporation, the state in which the holding company or controlling affiliate has its
122 principal place of business as determined using the above factors; ~~and~~ <u>however</u>

123 (vii) In the case of a plan sponsor, if more than 50 percent of the participants in the benefit
124 plan are employed in a single state, that state shall be deemed to be the principal place of
125 business of the plan sponsor.

126 (B) The principal place of business of a plan sponsor of a benefit plan described in
127 ~~paragraph (C), subdivision (16) of this section~~ §33-26A-5(17)(C) of this code shall be deemed to
128 be the principal place of business of the association, committee, joint board of trustees, or other
129 similar group of representatives of the parties who establish or maintain the benefit plan that, in
130 lieu of a specific or clear designation of a principal place of business, shall be deemed to be the
131 principal place of business of the employer or employee organization that has the largest
132 investment in the benefit plan in question.

133 (20) “Receivership court” means the court in the insolvent or impaired insurer’s state
134 having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

135 (21) “Resident” means a person to whom a contractual obligation is owed and who resides
136 in this state on the date of entry of a court order that determines a member insurer to be an
137 impaired insurer or a court order that determines a member insurer to be an insolvent insurer,
138 whichever occurs first. A person may be a resident of only one state, which in the case of a person
139 other than a natural person shall be its principal place of business. Citizens of the United States
140 that are either residents of foreign countries or residents of United States possessions, territories,
141 or protectorates that do not have an association similar to the association created by this article,
142 shall be deemed residents of the state of domicile of the member insurer that issued the policies
143 or contracts.

144 (22) “Structured settlement annuity” means an annuity purchased in order to fund periodic
145 payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered
146 by the plaintiff or other claimant.

147 ~~(23) "Health insurance" means accident and sickness insurance as defined in subsection~~
148 ~~(b), section ten, article one of this chapter and benefits provided pursuant to articles twenty-four~~
149 ~~and twenty-five of this chapter~~
150 ~~(24)~~ (23) "Supplemental contract" means ~~any~~ a written agreement entered into for the
151 distribution of proceeds under a life, health, or annuity policy or contract ~~proceeds~~.
152 ~~(25)~~ (24) "Unallocated annuity contract" means any annuity contract or group annuity
153 certificate which is not issued to and owned by an individual, except to the extent of any annuity
154 benefits guaranteed to an individual by an insurer under such contract or certificate.

§33-26A-6. Creation of association; required accounts; supervision of commissioner; meetings and records.

1 (a) There is created a nonprofit legal entity to be known as the West Virginia Life and
2 Health Insurance Guaranty Association. All member insurers shall be and remain members of the
3 association as a condition of their authority to transact insurance or a health maintenance
4 organization business in this state. The association shall perform its functions under the plan of
5 operation established and approved under §33-26A-10 of this code and shall exercise its powers
6 through a board of directors established under §33-26A-7 of this code. For purposes of
7 administration and assessment, the association shall maintain the following two accounts:
8 (1) The life insurance and annuity account which includes the following subaccounts:
9 (A) Life insurance account;
10 (B) Annuity account which shall include annuity contracts owned by a governmental
11 retirement plan or its trustee established under section 401, 403(b), or 457 of the United States
12 Internal Revenue Code, but shall otherwise exclude unallocated annuities; and
13 (C) Unallocated annuity account which shall exclude contracts owned by a governmental
14 retirement plan or its trustee established under section 401, 403(b), or 457 of the United States
15 Internal Revenue Code.
16 (2) The health ~~insurance~~ account.

17 (b) The association shall come under the immediate supervision of the commissioner and
18 shall be subject to the applicable provisions of the insurance laws of this state. Meetings or
19 records of the association may be opened to the public upon majority vote of the board of directors
20 of the association.

§33-26A-7. Board of directors; members; vacancies; voting rights; appointment and reimbursement.

1 (a) The board of directors of the association shall consist of not less than ~~five~~ seven nor
2 more than ~~nine~~ 11 member insurers serving terms as established in the plan of operation. The
3 members of the board shall be selected by member insurers subject to the approval of the
4 commissioner. Vacancies on the board shall be filled for the remaining period of the term by a
5 majority vote of the remaining board members, subject to the approval of the commissioner.
6 (b) To select the initial board of directors, and initially organize the association, the
7 commissioner shall give notice to all member insurers of the time and place of the organizational
8 meeting. In determining voting rights at the organizational meeting, each member insurer shall be
9 entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days
10 after notice of the organizational meeting, the commissioner may appoint the initial members.
11 (c) In approving selections or in appointing members to the board, the commissioner shall
12 consider, among other things, whether all member insurers are fairly represented.
13 (d) Members of the board may be reimbursed from the assets of the association for
14 expenses incurred by them as members of the board of directors but members of the board shall
15 not otherwise be compensated by the association for their services.

§33-26A-8. Powers and duties of association.

1 (a) If a member insurer is an impaired insurer, the association may, in its discretion, and
2 subject to any conditions imposed by the association that do not impair the contractual obligations
3 of the impaired insurer, that are approved by the commissioner:
4 (1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed,

5 reissued, or reinsured, any or all of the covered policies or contracts of the impaired insurer; or

6 (2) Provide such moneys, pledges, notes, guarantees, or other means as are proper to

7 effectuate §33-26A-8(a)(1) of this code and assure payment of the contractual obligations of the

8 impaired insurer pending action under said §33-26A-8(a)(1) of this code.

9 (b) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

10 (1) (A) (i) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed,

11 reissued, or reinsured, the policies or contracts of the insolvent insurer; or

12 (ii) Assure payment of the contractual obligations of the insolvent insurer; and

13 (B) Provide moneys, pledges, guarantees, or other means as are reasonably necessary

14 to discharge such duties; or

15 (2) Provide benefits and coverages in accordance with the following provisions:

16 (A) With respect to ~~life and health insurance policies and annuities~~ policies and contracts,

17 assure payment of benefits ~~for premiums identical to the premiums and benefits, except for terms~~

18 ~~of conversion and renewability,~~ that would have been payable under the policies or contracts of

19 the insolvent insurer, for claims incurred:

20 (i) With respect to group policies and contracts, not later than the earlier of the next

21 renewal date under such policies or contracts or 45 days, but in no event less than 30 days, after

22 the date on which the association becomes obligated with respect to such policies and contracts;

23 (ii) With respect to nongroup policies, contracts, and annuities, not later than the earlier of

24 the next renewal date, if any, under these policies or contracts or one year, but in no event less

25 than 30 days, from the date on which the association becomes obligated with respect to such

26 policies or contracts;

27 (B) Make diligent efforts to provide all known insureds, enrollees, or annuitants, or group

28 ~~policyholders~~ policy or contract owners with respect to group policies and contracts 30-days'

29 notice of the termination (pursuant to §33-26A-8(b)(2)(A) of this code) of the benefits provided

30 ~~pursuant to paragraph (A) of this subdivision~~; ~~and~~

31 (C) With respect to nongroup ~~life and health insurance policies and annuities~~ policies and
32 contracts covered by the association, make available to each known insured, enrollee, or
33 annuitant, or owner if other than the insured or annuitant, and with respect to an individual ~~formerly~~
34 ~~insured or~~ formerly an insured, enrollee, or annuitant under a group policy or contract who is not
35 eligible for replacement group coverage, make available substitute coverage on an individual
36 basis in accordance with the provisions of §33-26A-8(b)(2)(D) of this code, if the insureds,
37 enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to
38 convert coverage to individual coverage or to continue an individual policy, contract, or annuity in
39 force until a specified age or for a specified time, during which the insurer or health maintenance
40 organization had no right unilaterally to make changes in any provision of the policy, contract, or
41 annuity or had a right only to make changes in premium by class;
42 (D) (i) In providing the substitute coverage required under §33-26A-8(b)(2)(C) of this code,
43 the association may offer either to reissue the terminated coverage or to issue an alternative
44 policy or contract at actuarially justified rates, subject to the prior approval of the commissioner;
45 (ii) Alternative or reissued policies or contracts shall be offered without requiring evidence
46 of insurability, and shall not provide for any waiting period or exclusion that would not have applied
47 under the terminated policy or contract;
48 (iii) The association may reinsure any alternative or reissued policy or contract.
49 (E) (i) Alternative policies or contracts adopted by the association shall be subject to the
50 approval of the ~~domiciliary~~ commissioner. ~~and the receivership court~~ The association may adopt
51 alternative policies or contracts of various types for future issuance without regard to any
52 particular impairment or insolvency.
53 (ii) Alternative policies or contracts shall contain at least the minimum statutory provisions
54 required in this state and provide benefits that shall not be unreasonable in relation to the premium
55 charged. The association shall set the premium in accordance with a table of rates which it shall
56 adopt. The premium shall reflect the amount of insurance to be provided and the age and class

57 of risk of each insured, but shall not reflect any changes in the health of the insured after the

58 original policy or contract was last underwritten.

59 (iii) Any alternative policy or contract issued by the association shall provide coverage of

60 a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as

61 determined by the association.

62 (F) If the association elects to reissue terminated coverage at a premium rate different

63 from that charged under the terminated policy or contract, the premium shall be actuarially justified

64 and set by the association in accordance with the amount of insurance or coverage provided and

65 the age and class of risk, subject to prior approval of the ~~domiciliary commissioner and the~~

66 ~~receivership court~~ commissioner;

67 (G) The association's obligations with respect to coverage under any policy or contract of

68 the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease

69 on the date that the coverage or policy or contract is replaced by another similar policy or contract

70 by the policy or contract owner, ~~policyholder~~ the insured, the enrollee, or the association;

71 (H) When proceeding under ~~subdivision (2) of this subsection~~ this subdivision with respect

72 to any policy or contract carrying guaranteed minimum interest rates, the association shall assure

73 the payment or crediting of a rate of interest consistent with §33-26A-3(b)(2)(C) of this code.

74 (c) Nonpayment of premium within 31 days after the date required under the terms of any

75 guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall

76 terminate the association's obligations under such policy, contract, or coverage under this article

77 with respect to such policy, contract, or coverage, except with respect to any claims incurred or

78 any net cash surrender value which may be due in accordance with the provisions of this article.

79 (d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer

80 shall belong to and be payable at the direction of the association. If the liquidator of an insolvent

81 insurer requests, the association shall provide a report to the liquidator regarding such premium

82 collected by the association. The association shall be liable for unearned premiums due to policy

83 or contract owners arising after the entry of the order.

84 (e) The protection provided by this article shall not apply where any guaranty protection is
85 provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired
86 or insolvent insurer other than this state.

87 (f) In carrying out its duties under §33-26A-8(b) of this code, the association may, subject
88 to approval by a court in this state:

89 (1) Impose permanent policy or contract liens in connection with any guarantee,
90 assumption, or reinsurance agreement, if the association finds that the amounts which can be
91 assessed under this article are less than the amounts needed to assure full and prompt
92 performance of the association's duties under this article, or that the economic or financial
93 conditions as they affect member insurers are sufficiently adverse to render the imposition of such
94 permanent policy or contract liens, to be in the public interest;

95 (2) Impose temporary moratoriums or liens on payments of cash values and policy loans,
96 or any other right to withdraw funds held in conjunction with policies or contracts, in addition to
97 any contractual provisions for deferral of cash or policy loan value. In the event of a temporary
98 moratorium or moratorium charge imposed by the receivership court on payment of cash values
99 or policy loans, or on any other right to withdraw funds held in conjunction with policies or
100 contracts, out of the assets of the impaired or insolvent insurer, the association may defer the
101 payment of cash values, policy loans, or other rights by the association for the period of the
102 moratorium or moratorium charge imposed by the receivership court, except for claims covered
103 by the association to be paid in accordance with a hardship procedure established by the
104 liquidator or rehabilitator and approved by the receivership court.

105 (g) A deposit in this state, held pursuant to law or required by the commissioner for the
106 benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator
107 upon the entry of a final order of liquidation or order approving a rehabilitation plan of ~~an~~ a member
108 insurer domiciled in this state or in a reciprocal state, pursuant to §33-10-1 *et seq.* of this code,

109 shall be promptly paid to the association. The association shall be entitled to retain a portion of
110 any amount so paid to it equal to the percentage determined by dividing the aggregate amount of
111 policy or contract owners' claims related to that insolvency for which the association has provided
112 statutory benefits by the aggregate amount of all policy or contract owners' claims in this state
113 related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the
114 association less the amount retained pursuant to this subsection. Any amount so paid to the
115 association and retained by it shall be treated as a distribution of estate assets pursuant to §33-
116 10-1 *et seq.* of this code.

117 (h) If the association fails to act within a reasonable period of time with respect to an
118 insolvent insurer as provided in §33-26A-8(b) of this code, the commissioner shall have the
119 powers and duties of the association under this article with respect to the insolvent insurer.

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

123 (j) The association shall have standing to appear or intervene before any court in this state
124 with jurisdiction over an impaired or insolvent insurer concerning which the association is or may
125 become obligated under this article. ~~standing~~ Standing shall extend to all matters germane to the
126 powers and duties of the association, including, but not limited to, proposals for reinsuring,
127 reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer
128 and the determination of the policies or contracts and contractual obligations. The association
129 shall also have the right to appear or intervene before a court or agency in another state with
130 jurisdiction over an impaired or insolvent insurer for which the association is or may become
131 obligated or with jurisdiction over any person or property against whom the association may have
132 rights through subrogation ~~of the insurer's policyholders, payees, or beneficiaries~~ or otherwise.

133 (k) (1) Any person receiving benefits under this article shall be deemed to have assigned
134 the rights under, and any causes of action against any person for losses arising under, resulting

135 from, or otherwise relating to, the covered policy or contract to the association to the extent of the
136 benefits received because of this article, whether the benefits are payments of or on account of
137 contractual obligations, continuation of coverage, or provision of substitute or alternative policies,
138 contracts, or coverages. The association may require an assignment to it of such rights and cause
139 of action by any enrollee, payee, policy, or contract owner, beneficiary, insured, or annuitant as a
140 condition precedent to the receipt of any right or benefits conferred by this article upon such
141 person.

142 (2) The subrogation rights of the association under this subsection shall have the same
143 priority against the assets of the impaired or insolvent insurer as that possessed by the person
144 entitled to receive benefits under this article.

145 (3) In addition to §33-26A-8(k)(1) and §33-26A-8(k)(2) of this code, the association shall
146 have all common law rights of subrogation and any other equitable or legal remedy that would
147 have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, payee, or
148 insured of a policy or contract with respect to such policy or contracts.

149 (4) If the preceding provisions of this subsection are invalid or ineffective with respect to
150 any person or claim for any reason, the amount payable by the association with respect to the
151 related covered obligations shall be reduced by the amount realized by any other person with
152 respect to the person or claim that is attributable to the policies or contracts, or portion thereof,
153 covered by the association.

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

158 (l) In addition to the rights and powers elsewhere in this article, the association may:

159 (1) Enter into such contracts as are necessary or proper to carry out the provisions and
160 purposes of this article;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under §33-26A-9 of this code and to settle claims or potential claims against it;

(3) Borrow money to effect the purpose of this article; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this article;

(5) Take such legal action as may be necessary to avoid or recover payment of improper claims;

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

(7) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this article with respect to the person, and the person shall promptly comply with the request; ~~and~~

(9) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this article; and

~~(9)~~ (10) Take other necessary or appropriate action to discharge its duties and obligations under this article or to exercise its powers under this article.

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

187 (n) (1) (A) At any time within 180 days of the date of the order of liquidation, the association
188 may elect to succeed to the rights and obligations of the ceding member insurer that relate to
189 policies, contracts, or annuities covered, in whole or in part, by the association, in each case under
190 any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and
191 selected by the association. Any such assumption shall be effective as of the date of the order of
192 liquidation. The election shall be effected by the association or the National Organization of Life
193 and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice,
194 return receipt requested, to the affected reinsurers.

195 (B) To facilitate the earliest practicable decision about whether to assume any of the
196 contracts of reinsurance, and in order to protect the financial position of the estate, the receiver
197 and each reinsurer of the ceding member insurer shall make available upon request to the
198 association or to NOLHGA on its behalf as soon as possible after commencement of formal
199 delinquency proceedings: (i) Copies of in-force contracts of reinsurance and all related files and
200 records relevant to the determination of whether such contracts should be assumed; and (ii)
201 notices of any defaults under the reinsurance contacts or any known event or condition which with
202 the passage of time could become a default under the reinsurance contracts.

203 (C) The following subparagraphs shall apply to reinsurance contracts so assumed by the
204 association:

205 (i) The association shall be responsible for all unpaid premiums due under the reinsurance
206 contracts for periods both before and after the date of the order of liquidation, and shall be
207 responsible for the performance of all other obligations to be performed after the date of the order
208 of liquidation, in each case which relate to policies, contracts, or annuities covered, in whole or in
209 part, by the association. The association may charge policies, contracts, or annuities covered in
210 part by the association, through reasonable allocation methods, the costs for reinsurance in
211 excess of the obligations of the association and shall provide notice and an accounting of these
212 charges to the liquidator.

213 (ii) The association shall be entitled to any amounts payable by the reinsurer under the
214 reinsurance contracts with respect to losses or events that occur in periods after the date of the
215 order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part,
216 by the association, provided that, upon receipt of any such amounts, the association shall be
217 obliged to pay to the beneficiary under the policy, contract, or annuity on account of which the
218 amounts were paid a portion of the amount equal to lesser of:
219 (I) The amount received by the association; and
220 (II) The excess of the amount received by the association over the amount equal to the
221 benefits paid by the association on account of the policy, contract, or annuity less the retention of
222 the insurer applicable to the loss or event.
223 (iii) Within 30 days following the association's election (the "election date"), the association
224 and each reinsurer under contracts assumed by the association shall calculate the net balance
225 due to or from the association under each reinsurance contract as of the election date with respect
226 to policies, contracts, or annuities covered, in whole or in part, by the association, which
227 calculation shall give full credit to all items paid by either the member insurer or its receiver or the
228 reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for
229 losses or events prior to the date of the order of liquidation, subject to any set-off for premiums
230 unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining
231 balance due the other, in each case within five days of the completion of the aforementioned
232 calculation. Any disputes over the amounts due to either the association or the reinsurer shall be
233 resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the
234 contract contains no arbitration clause, as otherwise provided by law. If the receiver has received
235 any amounts due the association pursuant to §33-26A-8(n)(1)(C)(ii) of this code, the receiver shall
236 remit the same to the association as promptly as practicable.
237 (iv) If the association or receiver, on the association's behalf, within 60 days of the election
238 date, pays the unpaid premiums due for periods both before and after the election date that relate

239 to policies, contracts, or annuities covered, in whole or in part, by the association, the reinsurer
240 shall not be entitled to terminate the reinsurance contracts for failure to pay premium insofar as
241 the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by
242 the association, and shall not be entitled to set off any unpaid amounts due under other contracts,
243 or unpaid amounts due from parties other than the association, against amounts due the
244 association.

245 (2) During the period from the date of the order of liquidation until the election date or, if
246 the election date does not occur, until 180 days after the date of the order of liquidation:

247 (A) (i) Neither the association nor the reinsurer shall have any rights or obligations under
248 reinsurance contracts that the association has the right to assume under §33-26A-8(n)(1) of this
249 code, whether for periods prior to or after the date of the order of liquidation; and

250 (ii) The reinsurer, the receiver, and the association shall, to the extent practicable, provide
251 each other data and records reasonably requested;

252 (B) Provided that once the association has elected to assume a reinsurance contract, the
253 parties' rights and obligations shall be governed by §33-26A-8(n)(1) of this code.

254 (3) If the association does not elect to assume a reinsurance contract by the election date
255 pursuant to §33-26A-8(n)(1) of this code, the association shall have no rights or obligations, in
256 each case for periods both before and after the date of the order of liquidation, with respect to the
257 reinsurance contract.

258 (4) When policies, contracts, or annuities, or covered obligations with respect thereto, are
259 transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also
260 be transferred by the association, in the case of contracts assumed under §33-26A-8(n)(1) of this
261 code, subject to the following:

262 (A) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance
263 contract transferred shall not cover any new policies of insurance, contracts, or annuities in
264 addition to those transferred;

265 (B) The obligations described in §33-26A-8(n)(1) of this code shall no longer apply with
266 respect to matters arising after the effective date of the transfer; and
267 (C) Notice shall be given in writing, return receipt requested, by the transferring party to
268 the affected reinsurer not less than 30 days prior to the effective date of the transfer.
269 (5) The provisions of this subsection shall supersede the provisions of any state law or of
270 any affected reinsurance contract that provides for or requires any payment of reinsurance
271 proceeds, on account of losses or events that occur in periods after the date of the order of
272 liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain
273 entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to
274 losses or events that occur in periods prior to the date of the order of liquidation, subject to
275 applicable setoff provisions.
276 (6) Except as otherwise provided in this subsection, nothing in this subsection shall alter
277 or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall
278 abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance
279 contract. Nothing in this subsection shall give a policyholder, contract owner, enrollee, certificate
280 holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set
281 forth in the reinsurance contract. Nothing in this subsection shall limit or affect the association's
282 rights as a creditor of the estate against the assets of the estate. Nothing in this subsection shall
283 apply to reinsurance agreements covering property or casualty risks.
284 (o) The board of directors of the association shall have discretion and may exercise
285 reasonable business judgment to determine the means by which the association is to provide the
286 benefits of this article in an economical and efficient manner.
287 (p) Where the association has arranged or offered to provide the benefits of this article to
288 a covered person under a plan or arrangement that fulfills the association's obligations under this
289 article, the person shall not be entitled to benefits from the association in addition to or other than
290 those provided under the plan or arrangement.

291 (q) Venue in a suit against the association arising under the article shall be in Kanawha
292 County. The association shall not be required to give an appeal bond in an appeal that relates to
293 a cause of action arising under this act.

294 (r) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or
295 reinsuring policies or contracts under §33-26A-8(a) or §33-26A-8(b) of this code, the association
296 may ~~subject to approval of the receivership court~~ issue substitute coverage for a policy or contract
297 that provides an interest rate, crediting rate, or similar factor determined by use of an index or
298 other external reference stated in the policy or contract employed in calculating returns or changes
299 in value by issuing an alternative policy or contract in accordance with the following provisions:

300 (1) In lieu of the index or other external reference provided in the original policy or contract,
301 the alternative policy or contract provides for:

302 (i) A fixed interest rate;

303 (ii) Payment of dividends with minimum guarantees; or

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

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

307 (3) The alternative policy or contract is substantially similar to the replaced policy or
308 contract in all other material terms.

§33-26A-9. Assessments.

1 (a) For the purpose of providing the funds necessary to carry out the powers and duties
2 of the association, the board of directors shall assess the member insurers, separately for each
3 account, at such time and for such amounts as the board finds necessary. Assessments shall be
4 due not less than 30 days after prior written notice to the member insurers and shall accrue
5 interest at 10 percent per annum on and after the due date.

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

7 (1) Class A assessments shall be authorized and called for the purpose of meeting

8 administrative and legal costs and other expenses. Class A assessments may be authorized and
9 called whether or not related to a particular impaired or insolvent insurer.
10 (2) Class B assessments shall be authorized and called to the extent necessary to carry
11 out the powers and duties of the association under §33-26A-8 of this code with regard to an
12 impaired or insolvent insurer.
13 (c) (1) The amount of any Class A assessment shall be determined by the board and may
14 be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide
15 that it be credited against future Class B assessments. ~~A nonpro rata assessment shall not exceed~~
16 ~~$300 per member insurer in any one calendar year. The amount of any Class B assessment shall~~
17 ~~be allocated for assessment purposes among the accounts pursuant to an allocation formula~~
18 ~~which may be based on the premiums or reserves of the impaired or insolvent insurer or any other~~
19 ~~standard deemed by the board in its sole discretion as being fair and reasonable under the~~
20 ~~circumstances~~
21 (2) The amount of any Class B assessment, except for assessments related to long-term
22 care insurance, shall be allocated for assessment purposes between the accounts and among
23 the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which
24 may be based on the premiums or reserves of the impaired or insolvent insurer or any other
25 standard determined by the board in its sole discretion as being fair and reasonable under the
26 circumstances.
27 (3) The amount of the Class B assessment for long-term care insurance written by the
28 impaired or insolvent insurer shall be allocated according to a methodology included in the plan
29 of operation and approved by the commissioner. The methodology shall provide for 50 percent
30 of the assessment to be allocated to accident and health member insurers and 50 percent to be
31 allocated to life and annuity member insurers.
32 ~~(2)~~ (4) Class B assessments against member insurers for each account and subaccount
33 shall be in the proportion that the premiums received on business in this state by each assessed

34 member insurer on policies or contracts covered by each account for the three most recent
35 calendar years for which information is available preceding the year in which the <u>member</u> insurer
36 became impaired or insolvent, as the case may be, bears to such premiums received on business
37 in this state for such calendar years by all assessed member insurers.

38 ~~(3)~~ <u>(5)</u> Assessments for funds to meet the requirements of the association with respect to
39 an impaired or insolvent insurer shall not be authorized or called until necessary to implement the
40 purposes of this article. Classification of assessments under §33-26A-9(b) of this code and
41 computation of assessments under this subsection shall be made with reasonable degree of
42 accuracy, recognizing that exact determinations may not always be possible. The association
43 shall notify each member insurer of its anticipated pro rata share of an authorized assessment
44 not yet called within 180 days after the assessment is authorized.

45 (d) The association may abate or defer, in whole or in part, the assessment of a member
46 insurer if, in the opinion of the board, payment of the assessment would endanger the ability of
47 the member insurer to fulfill its contractual obligations. ~~In the event~~ <u>If</u> an assessment against a
48 member insurer is abated or deferred in whole or in part, the amount by which such assessment
49 is abated or deferred may be assessed against the other member insurers in a manner consistent
50 with the basis for assessments set forth in this section. Once the conditions that caused a deferral
51 have been removed or rectified, the member insurer shall pay all assessments that were deferred
52 pursuant to a repayment plan approved by the association.

53 (e) (1) (A) Subject to the provisions of §33-26A-9(e)(1)(B) of this code, the total of all
54 assessments ~~upon~~ <u>authorized by the association with respect to</u> a member insurer for each
55 subaccount of the life and annuity account and for the health account shall not in any one calendar
56 year exceed two percent of such insurer's average <u>annual</u> premiums received in this state on the
57 policies and contracts covered by the subaccount or account during the three calendar years
58 preceding the year in which the <u>member</u> insurer became an impaired or insolvent insurer.

59 (B) If two or more assessments are authorized in one calendar year with respect to

60 <u>member</u> insurers that become impaired or insolvent in different calendar years, the average
61 annual premiums for purposes of the aggregate assessment percentage limitation referenced in
62 §33-26A-9(e)(1)(A) of this code shall be equal and limited to the higher of the three-year average
63 annual premiums for the applicable subaccount or account as calculated pursuant to this section.
64 (C) If the maximum assessment, together with the other assets of the association in an
65 account, does not provide in any one year in either account an amount sufficient to carry out the
66 responsibilities of the association, the necessary additional funds shall be assessed as soon
67 thereafter as permitted by this article.
68 (2) The board may provide in the plan of operation a method of allocating funds among
69 claims, whether relating to one or more impaired or insolvent insurers, when the maximum
70 assessment will be insufficient to cover anticipated claims.
71 (3) If the maximum assessment for any subaccount of the life and annuity account in any
72 one year does not provide an amount sufficient to carry out the responsibilities of the association,
73 then pursuant to §33-26A-9(c)(2) of this code, the board shall assess all subaccounts of the life
74 and annuity account for the necessary additional amount, subject to the maximum stated in §33-
75 26A-9(e)(1) of this code.
76 (f) The board may, by an equitable method as established in the plan of operation, refund
77 to member insurers, in proportion to the contribution of each <u>member</u> insurer to that account, the
78 amount by which the assets of the account exceed the amount the board finds is necessary to
79 carry out during the coming year the obligations of the association with regard to that account,
80 including assets accruing from assignment, subrogation, net realized gains, and income from
81 investments. A reasonable amount may be retained in any account to provide funds for the
82 continuing expenses of the association and for future claims.
83 (g) It shall be proper for any member insurer, in determining its premium rates and policy
84 owner dividends as to any kind of insurance <u>or health maintenance organization business</u> within
85 the scope of this article, to consider the amount reasonably necessary to meet its assessment

86 obligations under this article.

87 (h) The association shall issue to each member insurer paying an assessment under this
88 article, other than Class A assessment, a certificate of contribution, in a form prescribed by the
89 commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of
90 equal dignity and priority without reference to amounts or dates of issue. A certificate of
91 contribution may be shown by the member insurer in its financial statement as an asset in such
92 form and for such amount, if any, and period of time as the commissioner may approve.

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

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

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

105 (4) In the alternative to rendering a final decision with respect to a protest based on a
106 question regarding the assessment base, the association may refer protests to the commissioner
107 for a final decision, with or without a recommendation from the association.

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

111 (j) The association may request information of member insurers in order to aid in the

112 exercise of its power under this section, and member insurers shall promptly comply with a
113 request.

§33-26A-11. Duties and powers of commissioner of insurance.

1 In addition to the duties and powers enumerated elsewhere in this article:
2 (a) The commissioner shall:
3 (1) Upon request of the board of directors, provide the association with a statement of the
4 premiums in this and any other appropriate states for each member insurer;
5 (2) When an impairment is declared and the amount of the impairment is determined,
6 serve a demand upon the impaired insurer to make good the impairment within a reasonable time.
7 Notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the
8 impaired insurer to promptly comply with the demand shall not excuse the association from the
9 performance of its powers and duties under this article; and
10 (3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be
11 appointed as the liquidator or rehabilitator.
12 (b) The commissioner may suspend or revoke, after notice and hearing, the certificate of
13 authority to transact ~~insurance~~ business in this state of any member insurer which fails to pay an
14 assessment when due or fails to comply with the plan of operation. As an alternative, the
15 commissioner may levy a forfeiture on any member insurer which fails to pay an assessment
16 when due. The forfeiture shall not exceed five percent of the unpaid assessment per month, but
17 no forfeiture shall be less than $100 per month.
18 (c) ~~Any~~ A final action of the board of directors or the association may be appealed to the
19 commissioner by any member insurer if such appeal is taken within 60 days of its receipt of notice
20 of the final action being appealed. If a member company is appealing an assessment, the amount
21 assessed shall be paid to the association and available to meet association obligations during the
22 pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or
23 excess shall be returned to the member company. Any final action or order of the commissioner

24 shall be subject to judicial review in a court of competent jurisdiction.

25 (d) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all
26 interested persons of the effect of this article.

§33-26A-12. Prevention of insolvencies; duties of commissioner; coordination with board of directors; duties of the board of directors; requested examinations; procedures and reports.

1 To aid in the detection and prevention of member insurer insolvencies or impairments:

2 (a) It shall be the duty of the commissioner:

3 (1) To notify the commissioners of all the other states, territories of the United States, and
4 the District of Columbia within 30 days following the action taken or the date the action occurs,
5 when ~~he~~ the commissioner takes any of the following actions against a member insurer:

6 (A) Revocation of license;

7 (B) Suspension of license; or

8 (C) Makes any formal order that the member insurer ~~such company~~ restrict its premium
9 writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part
10 of its business, or increase capital, surplus, or any other account for the security of ~~policyholders~~
11 policy owners, contract owners, certificate holders, or creditors~~: Provided, That such notice shall~~
12 ~~be mailed to all commissioners within 30 days following the action taken or the date on which the~~
13 ~~action occurs~~.

14 (2) To report to the board of directors when ~~he or she~~ the commissioner has taken any of
15 the actions set forth in §33-26A-12(a)(1) of this code or has received a report from any other
16 commissioner indicating that any such action has been taken in another state. ~~Such~~ The report
17 to the board of directors shall contain all significant details of the action taken or the report
18 received from another commissioner.

19 (3) To report to the board of directors when ~~he or she~~ the commissioner has reasonable
20 cause to believe from any examination, whether completed or in process, of any member

21 ~~company~~ insurer that the ~~company~~ insurer may be an impaired or insolvent insurer.

22 (4) To furnish to the board of directors the ~~national association~~ National Association of

23 Insurance Commissioners (NAIC) ~~insurance regulatory information system~~ Insurance Regulatory

24 Information System (IRIS) ratios and listings of companies not included in the ratios developed

25 by the ~~national association of insurance commissioners~~ NAIC, and the board may use the

26 information contained therein in carrying out its duties and responsibilities under this section. The

27 report and the information contained therein shall be kept confidential by the board of directors

28 until it is made public by the commissioner or other lawful authority.

29 (b) The commissioner may seek the advice and recommendations of the board of directors

30 concerning any matter affecting his or her duties and responsibilities regarding the financial

31 condition of member insurers and ~~companies~~ insurers or health maintenance organizations

32 seeking admission to transact ~~insurance~~ business in this state.

33 (c) The board of directors may, upon majority vote, make reports and recommendations

34 to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or

35 conservation of any member insurer or germane to the solvency of any ~~company~~ insurer or health

36 maintenance organization seeking to do ~~an insurance~~ business in this state. The reports and

37 recommendations shall not be considered public documents.

38 (d) It shall be the duty of the board of directors, upon majority vote, to notify the

39 commissioner of any information indicating any member insurer may be an impaired or insolvent

40 insurer.

41 (e) ~~The board of directors may, upon majority vote, request that the commissioner order~~

42 ~~an examination of any member insurer which the board in good faith believes may be an impaired~~

43 ~~or insolvent insurer. Within 30 days of the receipt of a request, the commissioner shall begin an~~

44 ~~examination. The examination may be conducted as a national association of Insurance~~

45 ~~Commissioner's examination or may be conducted by persons that the commissioner designates.~~

46 ~~The cost of such examination shall be paid by the association, and the examination report shall~~

~~be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with §33-26A-12(a) of this code. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.~~

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

~~(g) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.~~

§33-26A-14. Miscellaneous provisions.

(a) Nothing in this article shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under §33-26A-8 of this code. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under §33-26A-15 of this code.

(c) For the purpose of carrying out its obligations under this article, the association shall

be deemed to be a creditor of the impaired or ~~insolent~~ insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as assignee or subrogee pursuant to ~~subsection (m), section eight of this article~~ §33-26A-8(k) of this code. All assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets which the reserves that should have been established for ~~the~~ such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in §33-26A-14(c) of this code and consistent with §33-10-1 *et seq.* of this code, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this article. If the liquidator has not, within 120 days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

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

38 (2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made
39 until and unless the total amount of valid claims of the association with interest thereon for funds
40 expended in carrying out its powers and duties under §33-26A-8 of this code with respect to the
41 member insurer have been fully recovered by the association.

42 ~~(e)~~(f)(1) If an order for liquidation or rehabilitation of ~~an~~ a member insurer domiciled in this
43 state has been entered, the receiver appointed under such order shall have a right to recover on
44 behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other
45 than stock dividends paid by the member insurer on its capital stock, made at any time during the
46 five years preceding the petition for liquidation or rehabilitation subject to the limitations of this
47 subsection.

48 (2) ~~Distribution shall not~~ No such distribution shall be recoverable if the member insurer
49 shows that when paid the distribution was lawful and reasonable, and that the member insurer
50 did not know and could not reasonably have known that the distribution might adversely affect the
51 ability of the member insurer to fulfill its contractual obligations.

52 (3) Any person who, as an affiliate, controlled the member insurer at the time the
53 distributions were paid shall be liable up to the amount of distributions ~~he or she~~ received. Any
54 person who, as an affiliate, controlled the member insurer at the time the distributions were
55 declared, shall be liable up to the amount of distributions ~~he or she~~ which would have been
56 received if they had been paid immediately. If two or more persons are liable with respect to the
57 same distributions, they shall be jointly and severally liable.

58 (4) The maximum amount recoverable under this subsection shall be the amount ~~required~~
59 needed in excess of all other available assets of the ~~impaired or~~ insolvent insurer to pay the
60 contractual obligations of the ~~impaired or~~ insolvent insurer.

61 (5) If any person under §33-26A-14(f)(3) of this code is insolvent, all its affiliates that
62 controlled it at the time the distribution was paid shall be jointly and severally liable for any
63 resulting deficiency in the amount recovered from the insolvent affiliate.

§33-26A-19. Prohibited advertisement of insurance guaranty association act in insurance sales; notice to policyholders.

(a) A person, including ~~any~~ a member insurer, agent, or affiliate of ~~an~~ a member insurer, shall not make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by the West Virginia ~~life and health insurance guaranty association act~~ Life and Health Insurance Guaranty Association Act: *Provided*, That this section shall not apply to the association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

(b) Within 180 days of the effective date of this ~~section~~ article, the association shall prepare a summary document describing the general purposes and current limitations of the act and complying with §33-26A-19(c) of this code. This document should be submitted to the commissioner for approval. Sixty days after receiving such approval, no member insurer may deliver a policy or contract described in §33-26A-3(b)(1) of this code to a policy owner, ~~or~~ contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, ~~or~~ contract owner, certificate holder, or enrollee prior to or at the time of delivery of the policy or contract except if §33-26A-19(d) of this code applies. The document should also be available upon request by a ~~policyholder~~ policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document shall not ~~mean~~ guarantee that either the policy or the contract ~~of the holder thereof would be~~ or the policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as

25 amendments to the ~~act~~ article may require. Failure to receive this document does not give the
26 ~~policyholder~~ policy owner, contract ~~holder~~ owner, certificate holder, enrollee, or insured any
27 greater rights than those stated in this article.

28 (c) The document prepared under §33-26A-19(b) of this code shall contain a clear and
29 conspicuous disclaimer on its face. The commissioner shall ~~promulgate a rule~~ propose rules for
30 legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code establishing
31 the form and content of the disclaimer. The disclaimer shall:

32 (1) State the name and address of the association and insurance department;

33 (2) Prominently warn the policy owner, ~~or~~ contract owner, certificate holder, or enrollee
34 that the association may not cover the policy or contract or, if coverage is available, it will be
35 subject to substantial limitations and exclusions and conditioned on continued residence in the
36 state;

37 (3) State the types of policies or contracts for which guaranty funds will provide coverage;

38 (4) State that the member insurer and its agents are prohibited by law from using the
39 existence of the association for the purpose of sales, solicitation, or inducement to purchase any
40 form of insurance or health maintenance organization coverage;

41 ~~(4)~~ (5) Emphasize that the policy owner, ~~or~~ contract owner, certificate holder, or enrollee
42 should not rely on coverage under the association when selecting an insurer or health
43 maintenance organization;

44 (6) Explain rights available and procedures for filing a complaint to allege a violation of
45 any provisions of this article; and

46 ~~(5)~~ (7) Provide other information as directed by the commissioner.

47 (d) An insurer or agent may not deliver a policy or contract described in §33-26A-3(b)(1)
48 of this code and excluded under §33-26A-3(b)(2)(A) of this code from coverage under this article
49 unless the insurer or agent, prior to or at the time of delivery, gives the policy owner, ~~or~~ contract
50 owner, certificate holder, or enrollee a separate written notice which clearly and conspicuously

51 discloses that the policy or contract is not covered by the association. The commissioner shall ~~by~~

52 ~~rule specify~~ propose rules for legislative approval in accordance with the provisions of §29A-3-1

53 *et seq.* of this code specifying the form and content of the notice~~, which rules shall be promulgated~~

54 ~~on or before August 2, 1993~~.

NOTE: The purpose of this bill is to ensure the West Virginia Life and Health Insurance Guaranty Association assesses member insurers in a fair and reasonable manner and has sufficient assessment capacity for all insolvencies, and to update article 26A of the Code of West Virginia to maintain consistency with the National Association of Insurance Commissioners Life and Health Insurance Guaranty Association Model Act.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.