WEST VIRGINIA CODE CHAPTER 33 ARTICLE 26A

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§33-26A-1. Short title.

This article shall be known and may be cited as the "West Virginia Life and Health Insurance Guaranty Association Act."

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

(a) The purpose of this article is to protect, subject to certain limitations, the persons specified in §33-26A-3(a) of this code against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or 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 by this article, and members of the association are subject to assessment to provide funds to carry out the purpose of this article.

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§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.

(2) To persons who are owners of or certificate holders or enrollees under 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 §33-26A-3(b) of this code, §33-26A-3(a)(1) and §33-26A-3(a)(2) of this code shall not apply, and this article shall, except as provided in §33-26A-3(a)(5) and §33-26A-3(a)(6) of this code, provide coverage to:

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

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

(4) For structured settlement annuities specified in §33-26A-3(b) of this code, §33-26A-3(a)(1) and §33-26A-3(a)(2) of this code shall not apply, and this article shall, except as provided in §33-26A-3(a)(5) and §33-26A-3(a)(6) of this code, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

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

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

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

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

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

(5) This article shall not provide coverage to:

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

(B) A person covered under §33-26A-3(a)(3) of this code, if any coverage is provided by the association of another state to the person; or

(C) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. § 5891, regardless of whether the transaction occurred before or after 26 U.S.C. § 5891 became effective.

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

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

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

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and any immediate or deferred annuity contracts.

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

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

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

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

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

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

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

(i) A multiple employer welfare arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144, as amended;

(ii) A minimum premium group insurance plan;

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

(iv) An administrative services only contract;

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

(i) Dividends or experience rating credits;

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(ii) Voting rights; or

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

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

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

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

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

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

(i) Claims based on marketing materials;

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

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

(iv) Extra-contractual claims; or

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

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

(L) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for

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purposes of determining the values that have been credited and are not subject to forfeiture, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

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

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

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

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

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

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

(i) $300,000 in life insurance death benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(ii) For health insurance benefits:

(I) $100,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance as defined in §33-15A-4 of this code, including any net cash surrender and net cash withdrawal values;

(II) $300,000 for disability income insurance, and $300,000 for long-term care insurance as defined in §33-15A-4 of this code;

(III) $500,000 for health benefit plans;

(iii) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

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(B) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(C) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

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

(i) An aggregate of $300,000 in benefits with respect to any one life under §33-26A-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 for health benefit plans under §33-26A-3(c)(2)(A)(ii) of this code, in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual; or

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

(E) With respect to either one contract owner provided coverage under §33-26A-3(a)(3)(B) of this code, or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in §33-26A-3(c)(2)(B) of this code, $5 million in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this article and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state. In no event shall the association be obligated to cover more than $5 million in benefits with respect to all of these unallocated contracts.

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

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

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

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§33-26A-4. Construction of article.

This article shall be liberally construed to effect the purpose under section two of this article which shall constitute an aid and guide to interpretation.

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§33-26A-5. Definitions.

As used in this article:

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

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

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

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

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

(6) “Commissioner” means the Insurance Commissioner of West Virginia.

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

(8) “Covered contract” or “covered policy” means any policy or contract within the scope of this article under §33-26A-3 of this code.

(9) “Extra-contractual claims” shall include, for example, claims relating to bad faith in the payment of claims, punitive, or exemplary damages or attorneys’ fees and costs.

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

(i) Accident only insurance;

(ii) Credit insurance;

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(iii) Dental only insurance;

(iv) Vision only insurance;

(v) Medicare Supplement insurance;

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

(vii) Disability income insurance;

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

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

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

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

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

(A) A fraternal benefit society;

(B) A mandatory state pooling plan;

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

(D) An insurance exchange;

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

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

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

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

(16) "Person" means any individual, corporation, limited liability company, partnership, association, or voluntary organization.

(17) "Plan sponsor" means:

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

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

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

(18) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less premiums, considerations, and deposits, and less dividends and experience credits thereon. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under §33-26A-3(b) of this code, except that assessable premium shall not be reduced on account of §33-26A-3(b)(2)(C) of this code relating to interest limitations and §33-26A-3(c)(2) of this code relating to limitations with respect to any one individual, one participant, and one policy or contract owner. Premiums shall not include:

(A) Premiums in excess of $5 million on any unallocated annuity contract not issued under a government retirement plan or its trustee established under sections 401, 403(b), or 457 of the United States Internal Revenue Code; or

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

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of policies or contracts held by the owner.

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

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

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

(iii) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings; and

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

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors; however

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

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

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

(21) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens

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of the United States that are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this article, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

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

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

(24) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

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

(a) There is created a nonprofit legal entity to be known as the West Virginia Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under §33-26A-10 of this code and shall exercise its powers through a board of directors established under §33-26A-7 of this code. For purposes of administration and assessment, the association shall maintain the following two accounts:

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

(A) Life insurance account;

(B) Annuity account which shall include annuity contracts owned by a governmental retirement plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and

(C) Unallocated annuity account which shall exclude contracts owned by a governmental retirement plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code.

(2) The health account.

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

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

(a) The board of directors of the association shall consist of not less than seven nor more than 11 member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(b) To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial members.

(c) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(d) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services.

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

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

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

(2) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate §33-26A-8(a)(1) of this code and assure payment of the contractual obligations of the impaired insurer pending action under said §33-26A-8(a)(1) of this code.

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

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

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

(B) Provide moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

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

(A) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

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

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

(B) Make diligent efforts to provide all known insureds, enrollees, or annuitants, or group policy or contract owners with respect to group policies and contracts 30-days' notice of the termination (pursuant to §33-26A-8(b)(2)(A) of this code) of the benefits provided;

(C) With respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make

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available substitute coverage on an individual basis in accordance with the provisions of §33-26A-8(b)(2)(D) of this code, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(D) (i) In providing the substitute coverage required under §33-26A-8(b)(2)(C) of this code, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the commissioner;

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

(iii) The association may reinsure any alternative or reissued policy or contract.

(E) (i) Alternative policies or contracts adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

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

(iii) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the commissioner;

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

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(H) When proceeding under this subdivision with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with §33-26A-3(b)(2)(C) of this code.

(c) Nonpayment of premium within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under such policy, contract, or coverage under this article with respect to such policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this article.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

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

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

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

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

(g) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary

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liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, pursuant to §33-10-1 et seq. of this code, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to §33-10-1 et seq. of this code.

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

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

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

(k) (1) Any person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy, or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this article upon such person.

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

(3) In addition to §33-26A-8(k)(1) and §33-26A-8(k)(2) of this code, the association shall have

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all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, payee, or insured of a policy or contract with respect to such policy or contracts.

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

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

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

(1) Enter into such contracts as are necessary or proper to carry out the provisions and 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, health insurer, or health maintenance organization, but in no case may the association issue policies or 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;

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(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

(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.

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

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

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

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

(ii) The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole

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or in part, by the association, provided that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to lesser of:

(I) The amount received by the association; and

(II) The excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contract, or annuity less the retention of the insurer applicable to the loss or event.

(iii) Within 30 days following the association's election (the "election date"), the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association pursuant to §33-26A-8(n)(1)(C)(ii) of this code, the receiver shall remit the same to the association as promptly as practicable.

(iv) If the association or receiver, on the association's behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by the association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due the association.

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

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

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

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

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

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

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

(B) The obligations described in §33-26A-8(n)(1) of this code shall no longer apply with respect to matters arising after the effective date of the transfer; and

(C) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days prior to the effective date of the transfer.

(5) The provisions of this subsection shall supersede the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

(6) Except as otherwise provided in this subsection, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this subsection shall give a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this subsection shall limit or affect the association's rights as a creditor of the estate against the assets of the estate. Nothing in this subsection shall apply to reinsurance agreements covering property or casualty risks.

(o) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this article in an economical and efficient manner.

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(p) Where the association has arranged or offered to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the association's obligations under this article, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

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

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

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

(i) A fixed interest rate;

(ii) Payment of dividends with minimum guarantees; or

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

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

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

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§33-26A-9. Assessments.

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

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

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

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under §33-26A-8 of this code with regard to an impaired or insolvent insurer.

(c) (1) The amount of any Class A assessment shall be determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments.

(2) The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard determined by the board in its sole discretion as being fair and reasonable under the circumstances.

(3) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers.

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

(5) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this article. Classification of assessments under §33-26A-9(b) of this code

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and computation of assessments under this subsection shall be made with reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

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

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

(B) If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in §33-26A-9(e)(1)(A) of this code shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(C) If the maximum assessment, together with the other assets of the association in an account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

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

(3) If the maximum assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to §33-26A-9(c)(2) of this code, the board shall assess all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in §33-26A-9(e)(1) of this code.

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(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future claims.

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

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

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

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

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

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

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

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

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§33-26A-10. Plan of operation.

(a) (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless he or she has not disapproved of the same within thirty days.

(2) If the association fails to submit a suitable plan of operation within one hundred eighty days following the effective date of this article or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this article:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under section seven of this article;

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(6) Establish any additional procedures for assessments under section nine of this article;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(8) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer; and

(9) Require the board of directors to establish a policy and procedures for addressing conflicts of interests.

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(d) The plan of operation may provide that any or all powers and duties of the association, except those under subdivision (3), subsection (l), section eight and section nine of this article, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

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

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

(a) The commissioner shall:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

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

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

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(c) A final action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within 60 days of its receipt of notice of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

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

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§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.

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

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

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

(A) Revocation of license;

(B) Suspension of license; or

(C) Makes any formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders, or creditors.

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

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

(4) To furnish to the board of directors the National Association of Insurance Commissioners (NAIC) Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until it is made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his or her duties and responsibilities regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in this state.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or

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conservation of any member insurer or germane to the solvency of any insurer or health maintenance organization seeking to do business in this state. The reports and recommendations shall not be considered public documents.

(d) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

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

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§33-26A-13. Appointment of special deputy.

The association may recommend a natural person to serve as a special deputy to act for the commissioner and under his or her supervision in the liquidation, rehabilitation or conservation of any member insurer.

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§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 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 §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 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 policy owners, contract

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owners, certificate holders, and enrollees of the continuing or successor member insurer.

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

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

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

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

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

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

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§33-26A-15. Examination of association; annual report.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of its activities during the preceding calendar year.

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§33-26A-16. Tax exemptions.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

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§33-26A-17. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his or her representatives, for any action or omission by them in the performance of their powers and duties under this article. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

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§33-26A-18. Stay of court proceedings; reopening default judgments.

All proceedings in which the impaired or insolvent insurer is a party in any court in this state shall be stayed one hundred eighty days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict or finding based on default the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

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

(a) A person, including a member insurer, agent, or affiliate of 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: 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 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 shall 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, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder, or enrollee prior to or at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document shall not guarantee that either the policy or the contract 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 amendments to the article may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this article.

(c) The document prepared under §33-26A-19(b) of this code shall contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer shall:

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

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

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

(4) State that the member insurer and its agents are prohibited by law from using the

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existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

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

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

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

(d) A member insurer shall retain evidence of compliance with §33-26A-19(b) of this code for so long as the policy or contract for which the notice is given remains in effect.

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