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HOUSE BILL NO. 1486

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Commerce and Labor on February 8, 2018)

(Patron Prior to Substitute—Delegate Kilgore)

A BILL to amend and reenact §§ 38.2-1016.1, 38.2-1700 through 38.2-1710, 38.2-1714, 38.2-1715, 38.2-4302, 38.2-4310, 38.2-4319, 38.2-5506, 38.2-5509, 38.2-5510, and 55-532 of the Code of Virginia and to repeal §§ 38.2-4317 and 38.2-4317.1 of the Code of Virginia, relating to the Virginia Life, Accident and Sickness Insurance Guaranty Association.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-1016.1, 38.2-1700 through 38.2-1710, 38.2-1714, 38.2-1715, 38.2-4302, 38.2-4310, 38.2-4319, 38.2-5506, 38.2-5509, 38.2-5510, and 55-532 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-1016.1. Conversion of a health maintenance organization to an accident and sickness insurer.

A. Any health maintenance organization domiciled in the Commonwealth and subject to the provisions of Chapter 43 (§ 38.2-4300 et seq.) may, at its option and without reincorporation, convert to an insurer licensed to write accident and sickness insurance, hereinafter referred to as the "converted insurer," by following the procedures set forth in this section. A health maintenance organization that becomes a converted insurer under this section shall have all of the rights to and titles and interests in the assets of the original health maintenance organization, as well as all of its liabilities and obligations.

B. A health maintenance organization eligible to become a converted insurer under subsection A may effect such conversion by (i) complying with the requirements for formation of a domestic insurer under Article 1 (§ 38.2-1000 et seq.); (ii) promptly filing with the Commission any necessary amendments to its articles of incorporation, bylaws, and other corporate documents pursuant to the provisions of Chapter 9 (§ 13.1-601 et seq.) of Title 13.1; and (iii) filing with the Commission such other information as the Commission may require to meet all of the requirements of an insurer in Virginia. When those requirements have been met, the Commission shall issue a license in accordance with the provisions of Article 5 (§ 38.2-1024 et seq.) to permit the converted insurer to conduct the business of accident and sickness insurance in the Commonwealth. Upon the issuance of the converted insurer's license, and except as provided in this section, the converted insurer shall be subject to all of the provisions of this title that pertain to insurers licensed pursuant to Article 5 (§ 38.2-1024 et seq.) of this chapter and the business of accident and sickness insurance.

C. After the effective date of the health maintenance organization's conversion to and licensure as an insurer, all of the converted insurer's individual and group health care plans, contracts, and evidences of coverage shall remain valid and in force in accordance with their terms until the earlier of (i) the expiration or termination of the plans, contracts, or evidences of coverage; or (ii) the last day of the eighteenth month after the effective date of conversion. For the period during which the converted insurer continues to provide or arrange for health care services under such health care plan or plans, the insurer's obligation to pay license taxes under Chapter 25 (§ 58.1-2500 et seq.) of Title 58.1 and fees for maintaining the Bureau of Insurance under Chapter 4 (§ 38.2-400 et seq.), which are, in all cases, attributable to such health care plan or plans, shall be the same as the license taxes and fees required of health maintenance organizations generally.

D. Except as provided herein, a converted insurer shall not, after the effective date of its conversion, use in its accident and sickness insurance policies, contracts or other literature (i) the words "health maintenance organization" or "HMO" or (ii) any other words descriptive of a health maintenance organization or deceptively similar to the name or description of any health maintenance organization then doing business in the Commonwealth in any manner that misrepresents the benefits, advantages, conditions, or terms of the converted insurer's insurance policies, contracts, or other literature.

E. For the purposes of handling the rehabilitation, liquidation, or conservation of a converted insurer, the provisions of Chapter 15 (§ 38.2-1500 et seq.) shall apply. Whenever an order has been entered pursuant to Chapter 15 authorizing the Commission or other receiver to proceed with the rehabilitation, liquidation, or conservation of a converted insurer, the Commission may utilize the provisions of ~~§§~~ *§* 38.2-4310, ~~38.2-4317, and 38.2-4317.1~~ to protect the interests of enrollees in the converted insurer's health care plans. If a receivership occurs in a converted insurer that continues to provide or arrange for health care services under such health care plan or plans, contracts, or policies, the receiver shall consider these plans, contracts, or policies as existing in the converted insurer. The Commission or other receiver appointed pursuant to Chapter 15 shall allocate the assets, liabilities, and obligations of the insolvent converted insurer in the manner that the Commission or other receiver determines is fair and

equitable to the insurer's accident and sickness insurance policyholders, health care plan enrollees, and other creditors. The accident and sickness insurance contracts and policies issued by the converted insurer shall be governed by the provisions applicable to the Virginia Life, Accident and Sickness Insurance Guaranty Association pursuant to Chapter 17 (§ 38.2-1700 et seq.). The health care plans, contracts, or policies of the converted insurer, associated with the business written as a health maintenance organization, shall be governed by the provisions of ~~§§~~ *§* 38.2-4310~~, 38.2-4317, and 38.2-4317.1~~.

§ 38.2-1700. Purpose and applicability of chapter.

A. The purpose of this chapter is to protect, subject to certain limitations, the persons specified in subsection B against failure in the performance of contractual obligations, under life ~~and~~, accident and sickness insurance ~~policies~~, and annuity *policies, plans, or* contracts specified in subsection C because of the impairment or insolvency of the member insurer that issued the policies, *plans,* or contracts. This chapter shall be construed to effect this purpose. To provide this protection, an association of *member* insurers is created to pay benefits and to continue coverage as limited by this chapter, and members of the Association are subject to assessments to provide funds to carry out the purpose of this chapter.

B. This chapter shall provide coverage for the policies and contracts specified in subsection C as follows:

1. This chapter shall provide coverage, for the policies and contracts specified in subsection C, 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 accident and sickness insurance policies or certificates,* of the persons covered under subdivision B 2.

2. This chapter shall provide coverage, for the policies and contracts specified in subsection C, 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; or

b. Are not residents and (i) the *member* insurer that issued the policies or contracts is domiciled in the Commonwealth, (ii) the states in which the persons reside have associations similar to the Association, and (iii) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer *or 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 subsection C, subdivisions B 1 and B 2 shall not apply, and this chapter, except as provided in subdivisions B 5 and B 6, shall provide coverage to 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~~ *the* Commonwealth.

4. For structured settlement annuities specified in subsection C, subdivision B 1 and B 2 shall not apply and this chapter, except as provided in subdivisions B 5 and B 6, shall 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:

a. Is a resident, regardless of where the contract owner resides; or

b. Is not a resident and both (i) the contract owner of the structured settlement annuity is (a) a resident or (b) not a resident but the insurer that issued the structured settlement annuity is domiciled in the Commonwealth and the state in which the contract owner resides has an association similar to the Association; 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 chapter shall not provide coverage to:

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

b. A person covered under subdivision B 3 if any coverage is provided by the association of another state to the person.

6. This chapter is intended to provide coverage to a person who is a resident of the Commonwealth and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this 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 chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

C. This chapter shall:

1. Provide coverage to the persons specified in subsection B for *policies or contracts of* direct, nongroup life *insurance,* accident and sickness *insurance, which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates,* or ~~annuity policies or~~

~~contracts~~ *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, in each case except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts. This chapter shall apply also to dental benefit contracts entered into with a dental plan organization as provided in Chapter 61 (§ 38.2-6100 et seq.).

2. ~~Not~~ *Except as otherwise provided in subdivision 3, not* provide coverage for:

a. A portion of a policy or contract not guaranteed by ~~an~~ *a 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:

(1) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, 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 chapter, whichever is earlier; and

(2) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, 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:

(1) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;

(2) A minimum premium group insurance plan;

(3) A stop-loss agreement described in subsection B of § 38.2-109; or

(4) An administrative services only contract;

e. A portion of a policy or contract to the extent that it provides for:

(1) Dividends or experience rating credits;

(2) Voting rights; or

(3) 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 the Commonwealth by a member insurer at a time when its license to issue the policy or contract in the Commonwealth had been suspended, revoked, not renewed, or voluntarily withdrawn;

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 an unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan;

i. A portion of a policy or contract to the extent that the assessments required by § 38.2-1705 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:

(1) Claims based on marketing materials;

(2) 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;

(3) Misrepresentations of or regarding policy *or contract* benefits;

(4) Extra-contractual claims; or

(5) 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 chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract 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~~ *Chapter* 7 of Title 42 of the United States Code (known as Medicare Parts C and D)*; Subchapter XIX, Chapter 7 of Title 42 of the United States Code (known as Medicaid); § 32.1-352 (known as FAMIS);* or any regulations issued pursuant thereto; or

n. A charitable gift annuity as defined in § 38.2-106.1.

3. The exclusion from coverage referenced in subdivision 2 c shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other accident and sickness insurance benefits.

D. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

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

2. With respect to:

a. One life, regardless of the number of policies or contracts:

(1) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(2) ~~In health~~ *For accident and sickness* insurance benefits, (i) $100,000 for coverage not defined as disability *income* insurance, ~~basic hospital, medical and surgical insurance, major medical insurance~~ *health benefit plans,* or long-term care insurance including any net cash surrender and net cash withdrawal values; (ii) $300,000 for ~~accident and sickness insurance that constitutes~~ disability *income* insurance ~~or~~ *and $300,000 for* long-term care insurance; and (iii) $500,000 for ~~accident and sickness insurance that constitutes basic hospital medical and surgical insurance or major medical insurance~~ *health benefit plans*; and

(3) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

b. Each individual participating in a benefit plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code who (i) selected an investment option that includes investment in unallocated annuity contracts and (ii) is covered by such an unallocated annuity contract, including the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values;

c. 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; and

d. One plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts part or all of any of which is not included in subdivision 2 b, $5 million in benefits, irrespective of the number of contracts with respect to the plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit or 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 the Commonwealth and in no event shall the Association be obligated to cover more than $5 million in benefits with respect to all such unallocated contracts.

e. In no event shall the Association be obligated to cover (i) more than an aggregate of $350,000 in benefits with respect to any one life under subdivisions D 2 a, b, and c except with respect to benefits for ~~basic hospital, medical and surgical insurance, and major medical insurance~~ *health benefit plans* under subdivision D 2 a (2), 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.

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 chapter 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 chapter, 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 such rider relates.

E. In performing its obligations to provide coverage under § 38.2-1704, 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 the Association has determined, with the concurrence of the Commission, do not materially affect the economic values or economic benefits of the covered policy or contract.

§ 38.2-1701. Definitions.

As used in this chapter:

"Account" means any one of the two accounts created under § 38.2-1702.

"Association" means the Virginia Life, Accident and Sickness Insurance Guaranty Association created under § 38.2-1702.

"Authorized assessment" or the term "authorized" when used in the context of assessments means that 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.

"Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

"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.

"Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under § 38.2-1700.

"Covered *contract" or "covered* policy" means a policy or contract or portion of a policy or contract for which coverage is provided under § 38.2-1700.

"Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive damages, or attorney fees and costs.

"Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

1. Accident only insurance;

2. Credit insurance;

3. Dental only insurance;

4. Vision only insurance;

5. Medicare Supplement insurance;

6. Benefits for long-term care, home health care, community-based care, or any combination thereof;

7. Disability income insurance;

8. Coverage for on-site medical clinics; or

9. 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.

"Impaired insurer" means a member insurer considered by the Commission to be potentially unable to fulfill its contractual obligations.

"Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Member insurer" means an insurer *or health maintenance organization* licensed to transact in ~~this~~ *the* Commonwealth any class of insurance *or health maintenance organization business* to which this chapter applies under § 38.2-1700, including an insurer *or health maintenance organization* whose license to transact the business of insurance in the Commonwealth has been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include cooperative nonprofit life benefit companies, ~~health maintenance organizations,~~ mutual assessment life, accident and sickness insurance companies, burial societies, fraternal benefit societies, dental and optometric services plans, and health services plans not subject to this chapter pursuant to § 38.2-4213.

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

"Owner" of a policy or contract or *"policyholder,"* "policy owner," and "contract owner" means 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.

"Plan sponsor" means (i) the employer, in the case of a benefit plan established or maintained by a single employer; (ii) the employee organization in the case of a benefit plan established or maintained by an employee organization; or (iii) in the 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.

"Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts, less any returned premiums, considerations, and deposits and less dividends and experience credits. "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 subsection C of § 38.2-1700 except that assessable premium shall not be reduced on account of subdivision C 2 of § 38.2-1700 relating to interest limitations and subdivision D 2 of § 38.2-1700 relating to limitations with respect to one individual, one participant, and one *policy or* contract owner. "Premiums" shall not include (i) premiums for coverage in excess of $5 million on an unallocated annuity contract covered under ~~subdivision~~ *subdivisions* D 2 d, *e, and f* of § 38.2-1700 or (ii) 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 for coverage in excess of $5 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

"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 from which the management of the overall operations of the entity is directed; and 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 these factors. However, 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. The principal place of business of a plan sponsor described in clause (iii) of the definition of plan sponsor in this section 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.

"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.

"Resident" means a person to whom a contractual obligation is owed and who resides in the Commonwealth on the date a member insurer becomes an impaired insurer or a court order is entered that determines a member insurer to be an insolvent insurer. 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 of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories, or protectorates that do not have an association similar to the Association, shall be deemed residents of the state of domicile of the *member* insurer that issued the policies or contracts.

"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 or sickness suffered by the plaintiff or other claimant.

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

"Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual or a trust created by an individual for the benefit of one or more individuals, except to the extent of any annuity benefits guaranteed to an individual or such a trust by an insurer under the contract or certificate.

§ 38.2-1702. Association; creation; memberships; accounts; supervision.

A. The Association is a nonprofit legal entity known as the Virginia Life, Accident and Sickness Insurance Guaranty Association, created by former § 38.1-482.20. All member insurers shall be and

remain members of the Association as a condition of their license to transact the business of insurance *or the business of a health maintenance organization* in ~~this~~ *the* Commonwealth. The Association shall perform its functions under the plan of operation established and approved under § 38.2-1706 and shall exercise its powers through a board of directors established under § 38.2-1703. For purposes of administration and assessment, the Association shall maintain two accounts: (i) the accident and sickness insurance account; and (ii) the life insurance and annuity account, which includes the following subaccounts: (a) the life insurance account, (b) the annuity account, which shall include unallocated annuity contracts covered under subdivision D 2 b of § 38.2-1700, but shall otherwise exclude unallocated annuities, and (c) the unallocated annuity account, which shall consist of contracts covered under ~~subdivision~~ *subdivisions* D 2 d, *e, and f* of § 38.2-1700, but shall otherwise exclude unallocated annuities.

B. The Association shall come under the immediate supervision of the Commission and shall be subject to the applicable provisions of the insurance laws of the Commonwealth. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

§ 38.2-1703. Board of directors of Association.

A. The board of directors of the Association shall consist of not less than ~~five~~ *nine* nor more than ~~nine~~ *13* 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 Commission. Vacancies on the board shall be filled for the remainder of the term by a majority vote of the remaining board members, subject to the approval of the Commission.

B. In approving selections the Commission shall consider, among other things, whether all member insurers are fairly represented.

C. 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 be otherwise compensated by the Association for their services.

§ 38.2-1704. Powers and duties of Association.

In addition to the powers and duties enumerated in other sections of this chapter:

A. If the 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 and that are approved by the Commission:

1. Guarantee, assume, *reissue,* or reinsure, or cause to be guaranteed, assumed, *reissued,* or reinsured, any or all of the policies or contracts of the impaired insurer; and

2. Provide moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate subdivision 1 and assure payment of the contractual obligations of the impaired insurer pending action under that subdivision.

B. If the member insurer is an insolvent insurer, the Association shall, in its discretion and subject to the approval of the Commission, either:

1. a. Guarantee, assume, *reissue,* or reinsure or cause to be guaranteed, assumed, *reissued,* or reinsured the covered policies of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer; and

b. Provide moneys, pledges, notes, guarantees, or other means reasonably necessary to discharge its duties; or

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

a. With respect to ~~life and health insurance~~ policies and ~~annuities~~ *contracts*, assure payment of benefits ~~for premiums identical to the premiums and benefits, except for terms of conversion and renewability,~~ that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(1) With respect to group policies and contracts, not later than the earlier of the next renewal date under those 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 the policies and contracts;

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

b. Make diligent efforts to provide all known insureds, *enrollees,* or annuitants (for nongroup policies and contracts), or group policy *or contract* owners with respect to group policies and contracts, 30 days' notice of the termination, pursuant to subdivision 2 a, of the benefits provided;

c. With respect to nongroup ~~life and health insurance~~ policies and ~~annuities~~ *contracts* covered by the Association, make available to each known insured, *enrollee,* or annuitant, or owner if other than the insured, *enrollee,* or annuitant, and with respect to an individual formerly *an* insured, *enrollee,* or ~~formerly an~~ annuitant under a group policy *or contract* who is not eligible for replacement group

coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision 2 d, if the insureds, *enrollees,* or annuitants had a right under law or the terminated policy 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. In providing the substitute coverage required under subdivision 2 c, 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 Commission*. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy *or contract*. The Association may reinsure any alternative or reissued policy *or contract*;

e. Alternative policies *or contracts* adopted by the Association shall be subject to the approval of the ~~domiciliary~~ ~~insurance~~ ~~commissioner~~ ~~and~~ ~~the~~ ~~receivership~~ ~~court~~ *Commission*. The Association may adopt alternative policies *or contracts* of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies *or contracts* shall contain at least the minimum statutory provisions required in ~~this~~ *the* Commonwealth 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 that 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. 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 approval of the ~~domiciliary~~ ~~insurance~~ ~~commissioner~~ ~~and~~ ~~the~~ ~~receivership~~ ~~court~~ *Commission*;

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 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; and

h. When proceeding under subdivision B 2 with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with subdivision C 2 c of § 38.2-1700.

C. Nonpayment of premiums 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 the policy *or contract* or coverage under this chapter with respect to the policy, *contract,* or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with the provisions of this chapter.

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 chapter shall not apply where the Commission has determined that the foreign or alien insurer's domiciliary jurisdiction or state of entry provides substantially similar protection by statute or regulation for residents of ~~this~~ *the* Commonwealth.

F. In carrying out its duties under subsection B, the Association may:

1. Subject to approval by the Commission, impose permanent policy contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the Association's duties under this chapter, or that 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; and

2. Subject to approval by the Commission, 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 values. In addition, 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~~ *the* Commonwealth, held pursuant to law or required by the Commission for the benefit of creditors, including policy *or contract* owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of ~~an~~ *a member* insurer domiciled in ~~this~~ *the* Commonwealth or in a reciprocal state, pursuant to Article 7 (§ 38.2-1045 et seq.) of Chapter 10 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~~ *the* Commonwealth 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 applicable state receivership law dealing with early access disbursements.

H. If the Association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection B, the Commission shall have the powers and duties of the Association under this chapter with respect to the insolvent insurer.

I. The Association may render assistance and advice to the Commission, upon the Commission's request, concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

J. The Association shall have standing to appear or intervene before the Commission or any court or agency in the Commonwealth with jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this chapter or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association, including 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 chapter 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 chapter, 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 causes 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 chapter upon the person.

2. The subrogation rights of the Association under this subsection shall have the same priority against the assets of the insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

3. In addition to the rights provided by subdivisions K 1 and K 2, the Association shall have 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,* or payee of a policy or contract with respect to the policy or contract, including, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under § 130 of the Internal Revenue Code.

4. If ~~subdivision~~ *subdivisions* K 1 ~~through K~~, *2, and* 3 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 to which the Association has rights as described in subdivisions K 1 through K 4, 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 granted to it elsewhere in this chapter, the Association may:

1. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

2. Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 38.2-1705 and to settle any claims or potential claims against it;

3. Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the Association not in default shall be Category 1 investments, as defined in § 38.2-1401, for domestic *member* insurers;

4. Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform other functions as become necessary or proper under this chapter;

5. Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the Association;

6. Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

7. Exercise, for the purposes of this chapter and to the extent approved by the Commission, the powers of a domestic life ~~or~~ *insurer,* accident and sickness 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 chapter;

8. Organize itself as a corporation or in other legal form permitted by the laws of the Commonwealth;

9. Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; ~~and~~

10. *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 chapter; and*

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

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 any agent of the Association on the Association's 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 any agent of the Association on the Association's 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 contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

c. The following shall apply to reinsurance contracts so assumed by the Association:

(1) 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;

(2) 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 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 the 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;

(3) 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 contract 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 subdivision N 1 c (2), the receiver shall remit the same to the Association as promptly as practicable; and

(4) 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 related 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. Neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under subdivision N 1, whether for periods prior to or after the date of the order of liquidation; and the reinsurer, the receiver, and the Association shall, to the extent practicable, provide each other data and records reasonably requested;

b. Provided that once the Association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by subdivision N 1.

3. If the Association does not elect to assume a reinsurance contract by the election date pursuant to subdivision N 1, 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 subdivision N 1, 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 subdivision N 1 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 *Commonwealth* 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 section, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section shall give a policy holder, *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 section shall limit or affect the Association's rights as a creditor of the estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks.

O. The board of directors of the Association shall have discretion and may exercise good faith business judgment to determine the means by which the Association is to provide the benefits of this chapter in an economical and efficient manner.

P. Where the Association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the Association's obligations under this chapter, the person 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 this chapter shall be in the circuit court of the city or county in which the Association has its principal place of business except that any suit to which the Commission is a party shall be brought before the Commission. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

R. In carrying out its duties in connection with guaranteeing, assuming, *reissuing,* or reinsuring policies or contracts under subsection A or B, the Association may~~, subject to approval of the receivership court,~~ 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 for 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 similar to the replaced policy or contract in all other material terms.

§ 38.2-1705. 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 any amounts as the board finds necessary. Assessments shall be due not less than 30 days after prior written notice has been given to the member insurers. Late payments shall accrue interest from the due date compounded quarterly, based upon the average ~~90 day~~ *90-day* treasury bill rate for the most recently completed calendar quarter as published in the Federal Reserve Bulletin and shall be subject to a minimum charge of $50.

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 § 38.2-1704 with regard to an impaired or an insolvent insurer.

C. 1. The amount of any Class A assessment shall be determined by the board and may be authorized and called for current member insurers on a ~~pro rata~~ *pro rata* or ~~nonpro rata~~ *non-pro rata* basis. If pro rata, the board may provide that it be credited against future Class B assessments. ~~The total of all nonpro rata assessments shall not exceed $500 per member insurer in any one calendar year.~~ The amount of a Class B assessment, *except for assessments related to long-term care insurance,* shall be allocated for assessment purposes ~~among~~ *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 deemed by the board in its sole discretion as being fair and reasonable under the circumstances. *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 Commission. The methodology shall provide for 50 percent of the assessment to be allocated to accident and sickness member insurers and 50 percent to be allocated to life and annuity member insurers.*

2. In determining the shares that shall be allocated to the life insurance and annuity account pursuant to the methodology in subdivision C 1, the guaranty association shall use the following formula: =(0.50 - Life and annuity member insurers' share of Accident and Sickness Account) / (Life and annuity member insurers' share of Life Insurance and Annuity Account - Life and annuity member insurers' share of Accident and Sickness Account).

3. For the purposes of the methodology in subdivision C 1 and the formula in subdivision C 2 only, "life and annuity member insurer" means a member insurer for which (i) the sum of its assessable life insurance premiums and annuity premiums is greater than or equal to (ii) its assessable accident and sickness insurance premiums, which shall include its assessable health maintenance organization premiums but shall exclude its assessable premiums written for disability income and long-term care insurance. For purposes of this definition, assessable premiums shall be measured within the state. An "accident and sickness member insurer" means any member insurer not defined as a "life and annuity member insurer."

~~2.~~ *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~~ *the* Commonwealth by each assessed member insurer on policies or contracts covered by each account and subaccount for the three most recent calendar years for which information is available preceding the year in which the *member* insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most

recent calendar years for which information is available preceding the year in which the insurer became impaired, bear to such premiums received on business in ~~this~~ *the* Commonwealth for those calendar years by all assessed member insurers.

~~3.~~ *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 chapter. Classification of assessments under subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated ~~pro-rata~~ *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. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

E. 1. a. Subject to the provisions of subdivision E 1 b, the total of all assessments authorized by the Association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the accident and sickness ~~insurance~~ account shall not in any one calendar year exceed two percent of that member insurer's average annual premiums received in the Commonwealth 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 subdivision E 1 a 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 one year in that account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

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 a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to subdivision C 2, the board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision E 1.

F. If the Board of Directors of the Association determines that it has surplus funds on hand with respect to an insolvency, the Association shall, in accordance with the process set forth in the certificate of contribution for adjusting or cancelling the unamortized portion of the member insurer's certificate of contribution in the event of a reimbursement of assessment payments, use such surplus funds to reimburse member insurers for assessment costs not otherwise amortized and offset pursuant to § 38.2-1709 and pay the remaining surplus to the Department of Taxation, for deposit with the State Treasurer for credit to the general fund of the Commonwealth. Within 90 days of making payment of surplus funds to the Department of Taxation for deposit with the State Treasurer, the Association shall notify its member insurers of such payment. If any member insurer contends that it is entitled to any portion of the surplus refunded to the Commonwealth in order to recover assessment costs not otherwise amortized and offset pursuant to § 38.2-1709, then the member insurer may present evidence of such entitlement to the Department of Taxation. If the Department of Taxation determines that the member insurer is entitled to a portion of the surplus funds in order to recover assessment costs not otherwise amortized and offset pursuant to § 38.2-1709, then the State Treasurer shall pay to the member insurer the sum that the Department of Taxation determines that the member insurer is entitled to receive. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses and claims. For purposes of this subsection, "surplus funds" includes funds that the Association obtains by way of distributions or recoveries from receivers and third parties as reimbursement for its costs in connection with insolvencies and impairments in excess of reasonable amounts retained in an account to provide funds for the continuing expenses of the Association and for future losses and 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 chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

H. The Association shall issue to each *member* insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commission, for the amount of the assessment so paid excluding interest penalties. 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 Commission 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 Commission.

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 the protest to the Commission 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 ~~company~~ *insurer*. Interest on a refund due a protesting member *insurer* shall be paid at the rate actually earned by the Association.

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.

§ 38.2-1706. Plan of operation.

A. 1. The Association's plan of operation approved under former § 38.1-482.24 shall remain in effect until modified in accordance with this subsection. The Association shall from time to time submit to the Commission any amendments to the plan of operation necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. Any amendments to the plan of operation shall become effective upon the Commission's written approval or unless they have not been disapproved within 60 days.

2. If at any time the Association fails to submit suitable amendments to the plan, the Commission shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. The rules shall continue in force until modified by the Commission or superseded by an amended plan submitted by the Association and approved by the Commission.

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 chapter:

1. Establish procedures for handling assets of the Association;

2. Establish the amount and method of reimbursing members of the board of directors under § 38.2-1703;

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 Commission;

6. Establish any additional procedures for assessments under § 38.2-1705;

7. Establish a plan for equitable distribution of refunds to ~~members~~ *member insurers*;

8. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association;

9. 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

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

D. The plan of operation may provide that any or all powers and duties of the Association, except

those under subdivision L 3 of § 38.2-1704 and § 38.2-1705, are delegated to a corporation, association, or other organization that 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 Commission, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this chapter.

§ 38.2-1707. Duties and powers of the Commission.

A. In addition to the duties and powers enumerated elsewhere in this chapter, the Commission shall:

1. Upon request of the board of directors, provide the Association with a statement of the premiums in the 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 this demand shall not excuse the Association from the performance of its powers and duties under this chapter; and

3. Be appointed as the liquidator or rehabilitator in any liquidation or rehabilitation proceeding involving a domestic *member* insurer. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Commission shall be appointed conservator.

B. The Commission may suspend or revoke, after notice and hearing, the license to transact ~~the~~ business ~~of~~ ~~insurance~~ in ~~this~~ *the* Commonwealth of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the Commission may levy a forfeiture on any member insurer that 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. Any action of the board of directors or the Association may be appealed to the Commission by any member insurer if the appeal is taken within 30 days of the action being appealed. Any final action or order of the Commission shall be subject to judicial review in accordance with the provisions of §§ 12.1-39 through 12.1-41.

D. The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of this chapter.

§ 38.2-1708. Detection and prevention of insolvencies.

A. To aid in the detection and prevention of *member* insurer insolvencies, the Commission shall have the duty to:

1. Notify the insurance departments of all of the other states within 30 days following the action taken or the date the action occurs, when the Commission takes any of the following actions against a member insurer:

a. Revocation of license;

b. Suspension of license; or

c. Enters a formal order that the ~~company~~ *member insurer* restrict its premium writing, obtain additional contributions to surplus, withdraw from the Commonwealth, 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. Report to the board of directors when the Commission has taken any of the actions set forth in subdivision 1 or has received a report from any other insurance department 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 insurance department;

3. Report to the board of directors when the Commission has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the *member* insurer may be an impaired or insolvent insurer; and

4. 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 such time as made public by the Commission or other lawful authority.

B. The Commission may seek the advice and recommendations of the board of directors concerning any matter affecting its duties and responsibilities regarding the financial condition of member insurers and insurers *or health maintenance organizations* seeking admission to transact ~~the~~ business ~~of~~ ~~insurance~~

in the Commonwealth.

C. The board of directors may, upon majority vote, make reports and recommendations to the Commission upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any insurer *or health maintenance organization* seeking to transact ~~the~~ business ~~of~~ ~~insurance~~ in ~~this~~ *the* Commonwealth. These reports and recommendations shall not be considered public documents.

D. The board of directors, upon majority vote, may notify the Commission of any information indicating a member insurer may be an impaired or insolvent insurer.

E. The board of directors, upon majority vote, may make recommendations to the Commission for the detection and prevention of *member* insurer insolvencies.

§ 38.2-1709. Tax write-offs of certificates of contributions.

A. A member insurer shall have at its option the right to show a certificate of contribution as an asset in the form approved by the Commission pursuant to subsection H of § 38.2-1705 at the original face amount for the calendar year of issuance. Such amount shall be amortized over the 10 calendar years following the year the contribution was paid in amounts each equal to 10 percent of the amount of the contribution.

B. The *member* insurer may offset the amount of the certificate amortized in a calendar year as provided in subsection A. This amount shall be deducted from the premium tax liability incurred on business transacted in ~~this~~ *the* Commonwealth for that year. However, the Association shall diligently pursue all rights available to it to recover its expenditures made in the fulfillment of its responsibilities under this chapter. If the Commission determines after a hearing that the Association is not diligently pursuing available measures of recovery, the Commission shall notify the Department and contributing *member* insurers will not be able to offset amounts amortized during the period that the Commission determines that the Association has not been diligently pursuing available measures of recovery.

C. Any sums for which a certificate of contribution has been issued that have been (i) amortized by contributing insurers and offset against premium taxes as provided in subsection B and (ii) subsequently refunded pursuant to subsection F of § 38.2-1705 shall be paid to the Department of Taxation and deposited with the State Treasurer for credit to the general fund of ~~this~~ *the* Commonwealth.

D. The amount of any credit against premium taxes provided for in this section for ~~an~~ *a member* insurer shall be reduced by the amount of reduction in federal income taxes for any deduction claimed by the *member* insurer for an assessment paid pursuant to this chapter.

E. A member insurer that is exempt from taxes referenced in subsection A may recoup its assessments by a surcharge on its premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the Commission. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, the loss ratio, or agent commission. If a member insurer collects excess surcharges, the member insurer shall remit the excess amount to the Association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

§ 38.2-1710. Miscellaneous provisions.

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

B. Records shall be kept of all meetings of the board of directors to discuss the activities of the Association in carrying out its powers and duties under § 38.2-1704. The records of the Association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except (i) upon the termination of the impairment or insolvency of the *member* insurer or (ii) 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 § 38.2-1711.

C. For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies and contracts reduced by any amounts to which the Association is entitled as subrogee pursuant to subsection K of § 38.2-1704. Assets of the impaired or insolvent insurer attributable to covered policies and contracts shall be used to continue all covered policies and contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. "Assets attributable to covered policies and contracts" means that proportion of the assets which the reserves that should have been established for these policies and contracts bear to the reserves that should have been established for all insurance policies ~~and~~, contracts, *and health benefit plans* written by the impaired or insolvent insurer.

D. As a creditor of the impaired or insolvent insurer as established in subsection C and consistent with subsection B of § 38.2-1509, 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 chapter. If the liquidator

has not, within 120 days of a final determination of insolvency of ~~an~~ *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, in making an equitable distribution of the ownership rights of the insolvent insurer, may take into consideration the contributions of the respective parties, including the Association, the shareholders, *contract owners, certificate holders, enrollees,* and policy and contract owners of the insolvent insurer, and any other party with a legitimate interest. In this determination, consideration shall be given to the welfare of the policy ~~and~~ *owners,* contract owners, *certificate holders, and enrollees* of the continuing or successor *member* insurer.

2. No distribution to any 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 § 38.2-1704 with respect to the *member* insurer have been fully recovered by the Association.

F. 1. If an order for liquidation or rehabilitation of ~~an~~ *a member* insurer domiciled in ~~this~~ *the* Commonwealth has been entered, the receiver appointed under that 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 subdivisions 2 through 4.

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 was an affiliate that controlled the *member* insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the *member* insurer at the time the distributions were declared shall be liable up to the amount of distributions that 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 in excess of all other available assets of the insolvent insurer needed to pay (i) the contractual obligations of the insolvent insurer and (ii) the reasonable expenses of the Association incurred in connection with the performance of its duties for the insolvent insurer.

5. If any person liable under subdivision 3 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.

§ 38.2-1714. Stay of proceedings; reopening default judgments.

All proceedings in which the insolvent *member* insurer is a party in any court in this Commonwealth shall be stayed 180 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on all matters germane to its powers and duties. The Association may apply to have the judgment under any decision, order, verdict, or finding based on default set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

§ 38.2-1715. Prohibited advertisement of Association coverage in insurance sales; notice to policy owners.

A. No person, including ~~an~~ *a member* insurer, agent, or affiliate of ~~an~~ *a member* insurer, shall 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, that uses the existence of the Association of ~~this~~ *the* Commonwealth for the purpose of sales, solicitation, or inducement to purchase any form of insurance *or other coverage* covered by this chapter. This subsection shall not apply to the Association or any other entity that does not sell or solicit insurance *or coverage by a health maintenance organization.*

B. ~~By January 1, 2011, the~~ *The* Association shall prepare a summary document describing the general purposes and current limitations of this chapter and that complies with subsection C. This document shall be submitted to the Commission for approval. At the expiration of the sixtieth day after the date on which the Commission approves the document, ~~an~~ *a member* insurer may not deliver a policy or contract to a policy ~~or~~ *owner,* contract owner, *certificate holder, or enrollee* unless the

summary document is delivered to the policy ~~or~~ *owner,* contract owner, *certificate holder, or enrollee* at the time of delivery of the policy or contract. The document shall be posted on the Association's website and shall also be available upon request by a policy ~~or~~ *owner,* contract owner, *certificate holder, or enrollee*. The distribution, delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract or the *policy* owner ~~of the policy or~~, contract *owner, certificate holder, or enrollee* is covered in the event of the impairment or insolvency of a member insurer. The summary document shall be revised by the Association as amendments to the chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate owner, certificate holder, *enrollee,* or insured any greater rights than those stated in this chapter.

C. The document prepared under subsection B shall contain a clear and conspicuous disclaimer on its face. The Commission shall establish the form and content of the disclaimer. The disclaimer shall:

1. State the name and address of the Association and the Bureau of Insurance;

2. Prominently warn the policy ~~or~~ *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 Commonwealth;

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

5. State that the policy ~~or~~ *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 chapter; and

7. Provide other information as directed by the Commission including but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under the Freedom of Information Act (§ 2.2-3700 et seq.).

D. A member insurer shall retain evidence of compliance with subsection B for so long as the policy or contract for which the notice is given remains in effect.

§ 38.2-4302. Issuance of license; fee; minimum net worth; impairment.

A. The Commission shall issue a license to a health maintenance organization after the receipt of a complete application and payment of a $500 nonrefundable application fee if the Commission is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and reputable;

2. The health care plan constitutes an appropriate mechanism for the health maintenance organization to provide or arrange for the provision of, as a minimum, basic health care services or limited health care services on a prepaid basis, except to the extent of reasonable requirements for copayments, deductibles, or both;

3. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commission may consider:

a. The financial soundness of the health care plan's arrangements for health care services and the schedule of prepaid charges used for those services;

b. The adequacy of working capital;

c. Any agreement with an insurer, a health services plan, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health care plan is discontinued;

d. Any contracts with health care providers that set forth the health care services to be performed and the providers' responsibilities for fulfilling the health maintenance organization's obligations to its enrollees;

e. The deposit of acceptable securities in an amount satisfactory to the Commission, submitted in accordance with § 38.2-4310 as a guarantee that the obligations to the enrollees will be duly performed;

f. The applicant's net worth which shall include minimum net worth in an amount at least equal to the sum of uncovered expenses, but not less than $600,000, up to a maximum of $4 million; uncovered expenses shall be amounts determined from the most recently ended calendar quarter pursuant to regulations promulgated by the Commission; and

g. A financial statement of the health maintenance organization on the form required by § 38.2-4307;

4. The enrollees will be given an opportunity to participate in matters of policy and operation as required by § 38.2-4304; and

5. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-4301 or Chapter 58 (§ 38.2-5800 et seq.) or by independent investigation. Issuance of a license shall not constitute approval of the forms submitted under subdivisions *B* 6, 7, and

12 ~~of~~ ~~subsection~~ ~~B~~ of § 38.2-4301.

B. A licensed health maintenance organization shall have and maintain at all times the minimum net worth described in subdivision *A* 3 f ~~of~~ ~~subsection~~ ~~A~~ ~~of~~ ~~this~~ ~~section~~.

1. If the Commission finds that the minimum net worth of a domestic health maintenance organization is impaired, the Commission shall issue an order requiring the health maintenance organization to eliminate the impairment within a period not exceeding 90 days. The Commission may by order served upon the health maintenance organization prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If at the expiration of the designated period the health maintenance organization has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the health maintenance organization may be entered ~~as~~ ~~provided~~ ~~in~~ ~~§ 38.2-4317~~.

2. If the Commission finds an impairment of the minimum net worth of any foreign health maintenance organization, the Commission may order the health maintenance organization to eliminate the impairment and restore the minimum net worth to the amount required by this section. The Commission may, by order served upon the health maintenance organization, prohibit the health maintenance organization from issuing any new contracts while the impairment exists. If the health maintenance organization fails to comply with the Commission's order within a period of not more than 90 days, the Commission may, in the manner set out in § 38.2-4316, suspend or revoke the license of the health maintenance organization.

3. Prior to December 31, 1999, a health maintenance organization with less than minimum net worth which is licensed on and after June 30, 1998, may continue to operate as a licensed health maintenance organization without a finding of impairment if the licensee has net worth (i) on June 30, 1998, and up to December 31, 1998, in an amount at least equal to the sum of uncovered expenses, but not less than $300,000, up to a maximum of $2 million; (ii) on December 31, 1998, and up to June 30, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $400,000, up to a maximum of $2.5 million; and (iii) on June 30, 1999, and up to December 31, 1999, in an amount at least equal to the sum of uncovered expenses, but not less than $500,000, up to a maximum of $3 million.

§ 38.2-4310. Protection against insolvency.

A. Each health maintenance organization shall deposit and maintain acceptable securities with the State Treasurer in amounts prescribed by § 38.2-4310.1. The deposit shall be held as a special fund in trust, as a guarantee that the obligations to the enrollees who are residents of this Commonwealth will be performed. The securities shall be deposited pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership interests effected on the records of a depository and its participants pursuant to rules and procedures established by the depository. Upon a determination of insolvency or action by the Commission pursuant to § 38.2-4317, the deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of covered services to enrollees. If a health maintenance organization is placed in receivership, the deposit shall be an asset subject to the provisions of Chapter 15 (§ 38.2-1500 et seq.) of this title.

B. The Commission may require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Commission may require:

1. Insurance satisfactory in form and content to the Commission to cover the expenses to be paid for continued benefits after an insolvency;

2. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

3. Acceptable letters of credit; or

4. Any other arrangements to assure that benefits are continued as specified above.

~~C. 1. In the event of an insolvency of a health maintenance organization, all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a 30-day enrollment period commencing upon a date to be prescribed by the Commission. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates then in effect for its enrollees in such group.~~

~~2. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the Commission determines that the other health benefit plan lacks sufficient health care delivery resources to assure that health care services shall be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the Commission may allocate equitably the insolvent health maintenance organization's group contracts for such groups among all~~

~~health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.~~

~~3. The Commission may also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual coverage as determined by his type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.~~

~~D. 1. Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.~~

~~2. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those employees and dependents validly covered under the prior carrier's contract or policy on the date of discontinuance.~~

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, *Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.),* §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1,

38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-5506. Mandatory Control Level Event.

A. "Mandatory Control Level Event" means any of the following events:

1. The filing of an RBC Report which indicates that the licensee's Total Adjusted Capital is less than its Mandatory Control Level RBC;

2. The notification by the Commission to the licensee of an Adjusted RBC Report that indicates the event in subdivision A 1, provided the licensee does not challenge the Adjusted RBC Report under § 38.2-5507; or

3. If, pursuant to § 38.2-5507, the licensee challenges an Adjusted RBC Report that indicates the event in subdivision A 1, notification by the Commission to the licensee that the Commission has, after a hearing, rejected the licensee's challenge.

B. In the event of a Mandatory Control Level Event:

1. With respect to a life and health insurer, the Commission shall take actions as are necessary to place the insurer under regulatory control pursuant to the provisions of Chapter 15 (§ 38.2-1500 et seq.). In that event, the Mandatory Control Level Event shall be deemed an indication of a hazardous financial condition which serves as sufficient grounds for the Commission to commence delinquency proceedings, and the receiver appointed in conjunction with such proceedings, shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 15 or any order of liquidation, rehabilitation or conservation entered thereunder. If the Commission takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the appropriate provisions of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commission may forego action for up to ninety days after the Mandatory Control Level Event if the Commission finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

2. With respect to a property and casualty insurer, the Commission shall take actions as are necessary to place the insurer under regulatory control pursuant to the provisions of Chapter 15, or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue to run-off under the supervision of the Commission. In either event, the Mandatory Control Level Event shall be deemed an indication of a hazardous financial condition which serves as sufficient grounds for the Commission to commence delinquency proceedings, and the receiver appointed in conjunction with such proceedings, shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 15 or any order of liquidation, rehabilitation, or conservation entered thereunder. If the Commission takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the appropriate provisions of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commission may forego action for up to ninety days after the Mandatory Control Level Event if the Commission finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

3. With respect to a health organization, the Commission shall take actions as are necessary to place the health organization under regulatory control pursuant to and in accordance with applicable provisions in Chapter 15 (§ 38.2-1500 et seq.) and §§ 38.2-4214.1, ~~38.2-4317,~~ or § 38.2-4509.1 of this title. In that event, the Mandatory Control Level Event shall be deemed an indication of a hazardous financial

condition which serves as sufficient grounds for the Commission to commence delinquency proceedings, and the receiver appointed in conjunction with such proceedings shall have the rights, powers and duties with respect to the licensee as are set forth in Chapter 15, or any order of liquidation, rehabilitation or conservation entered thereunder. If the Commission takes actions pursuant to an adjusted RBC Report, the health organization shall be entitled to such protections as are afforded to the licensee under the appropriate provisions of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commission may forego action for up to ninety days after the Mandatory Control Level Event if the Commission finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

§ 38.2-5509. Supplemental provisions; rules; exemption.

A. The provisions of this Act are supplemental to any other provisions of the laws of this Commonwealth, and shall not preclude or limit any other powers or duties of the Commission, the Commissioner of Insurance, or any of the Commission's employees or agents under such laws, including, but not limited to, the provisions of §§ 38.2-1038 and 38.2-1040, ~~or~~ § *subdivision A 7 of* § 38.2-4316 ~~A 7 and 38.2-4317~~, and Chapter 15 (§ 38.2-1500 et seq.) and any regulations issued thereunder.

B. The Commission may adopt reasonable rules necessary for the implementation of this Act.

C. The Commission may exempt from the application of this Act any domestic property and casualty insurer which:

1. Writes direct business only in this Commonwealth;

2. Writes direct annual premiums of $2 million or less; and

3. Assumes no reinsurance in excess of five percent of direct premium written.

D. The Commission may exempt from the application of this Act an insurer organized and operating under the laws of this Commonwealth and licensed pursuant to the provisions of Chapter 25 (§ 38.2-2500 et seq.) ~~of this title~~.

E. The Commission may exempt from the application of this Act a domestic health organization that writes direct business only in this Commonwealth and assumes no reinsurance in excess of five percent of direct premium written, and either (i) writes direct annual premiums of two million dollars or less for comprehensive medical coverages or (ii) is licensed pursuant to Chapter 45 *(§ 38.2-4500 et seq.)* and covers less than 2,000 lives. As used in this subsection, "comprehensive medical coverages" means contracts providing basic health care services and Medicare and Medicaid risk coverages or policies providing hospital, surgical, major medical, Medicare risk and Medicaid risk coverages. Medicare supplement need not be included and premiums for administrative services shall not be included.

§ 38.2-5510. Foreign licensees.

A. Any foreign licensee shall, upon the written request of the Commission, submit to the Commission an RBC Report as of the end of the calendar year just ended not later than the later of:

1. The date an RBC Report would be required to be filed by a domestic licensee under this Act; or

2. Fifteen days after the request is received by the foreign licensee.

Any foreign licensee shall, at the written request of the Commission, promptly submit to the Commission a copy of any RBC Plan that is filed with the insurance commissioner of any other state.

B. In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to any foreign licensee as determined under the RBC statute applicable in the state of domicile of the licensee, or, if no RBC provision is in force in that state, under the provisions of this Act, if the insurance commissioner of the state of domicile of the foreign licensee fails to require the foreign licensee to file an RBC Plan in the manner specified under the RBC statute, or, if no RBC provision is in force in the state, under § 38.2-5503 hereof, the Commission may require the foreign licensee to file an RBC Plan with the Commission. In such event, the failure of the foreign licensee to file an RBC Plan with the Commission shall be grounds to order the licensee to cease writing new insurance business in this Commonwealth or to suspend, revoke or refuse to issue a license pursuant to § 38.2-1040.

C. In the event of a Mandatory Control Level Event with respect to any foreign licensee, if no domiciliary receiver has been appointed with respect to the foreign licensee under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign licensee, the Commission may deem such licensee in a condition where any further transaction of business will be hazardous to its policyholders, creditors, members, subscribers, stockholders, or to the public, and an action may be instituted and conducted pursuant to the provisions of Chapter 15 (§ 38.2-1500 et seq.) and, if applicable, §§ 38.2-4214.1~~, 38.2-4317,~~ or 38.2-4509.1, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application for such action.

§ 55-532. Obligations of nonprofit entity.

Prior to disposition of assets, any nonprofit entity shall provide to the Attorney General written notice, on a form provided by the Attorney General, of its intent to dispose of such assets, including the terms of the proposal. The notice shall be given at least 60 days in advance of the effective date of such

proposed transaction in order that the Attorney General may exercise his common law and statutory authority over the activities of these organizations. The Attorney General may employ expert assistance in reviewing any proposed transaction and such reasonable expenses incurred by the Attorney General shall be paid by a party to the proposed transaction.

Within 10 days of receipt of the notice from the entity, the Attorney General shall cause a public notice of the transaction to be published in a newspaper in which legal notices may be published in that jurisdiction.

No later than 40 days prior to any disposition of assets, the nonprofit entity shall convene a public meeting to set forth its expectations about how the health care needs of the community will be served following the proposed disposition of assets and to receive comments and respond to questions on the potential impact of the proposed disposition of assets on the community served by the nonprofit entity. Notice of the time and place of such meeting shall be published at least 10 days prior to the meeting in a newspaper in which legal notices may be published in that jurisdiction.

Notice to the Attorney General pursuant to this section shall be given for State Corporation Commission approval sought pursuant to Article 11 (§ 13.1-893.1 et seq.) of Chapter 10 of Title 13.1 and §§ 38.2-203 and 38.2-1322 through 38.2-1328 and subdivision A 1 of § 38.2-4316. Such notice need not be given where the State Corporation Commission determines, in its sole discretion, that there is a reasonable expectation that the foreign or domestic nonstock corporation licensed and subject to regulation under Chapter 42 (§ 38.2-4200 et seq.) of Title 38.2 or health maintenance organization referenced herein will not be able to meet its obligations to subscribers or enrollees.

The provisions of this section shall not apply to any disposition of assets subject to the provisions of § 38.2-4214.1 ~~or~~ ~~38.2-4317~~ or any of the provisions of Chapter 15 (§ 38.2-1500 et seq.) of Title 38.2.

2. That §§ 38.2-4317 and 38.2-4317.1 of the Code of Virginia are repealed.