As Reported by the House Insurance Committee

134th General Assembly
Regular Session **H. B. No. 530**
2021-2022

Representative Lampton
Cosponsors: Representatives Seitz, Hillyer, Carfagna, White

A BILL

To amend sections 3956.01, 3956.03, 3956.04, 3956.06, 3956.07, 3956.08, 3956.09, 3956.10, 3956.11, 3956.12, 3956.13, 3956.16, 3956.18, and 3956.20; to enact new section 3956.19; and to repeal section 3956.19 of the Revised Code to amend the law governing the Ohio Life and Health Insurance Guaranty Association.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3956.01, 3956.03, 3956.04, 3956.06, 3956.07, 3956.08, 3956.09, 3956.10, 3956.11, 3956.12, 3956.13, 3956.16, 3956.18, and 3956.20 be amended and new section 3956.19 of the Revised Code be enacted to read as follows:

Sec. 3956.01. As used in this chapter:

(A) "Account" means either of the two accounts created under section 3956.06 of the Revised Code.

(B) "Authorized assessment," or "authorized," in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called

immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(C) "Called assessment," or "called," 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 in the notice. An authorized assessment becomes a called assessment when notice is mailed, including by electronic means, by the association to member insurers.

(D) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy or contract, or portion of the policy or contract, for which coverage is provided under section 3956.04 of the Revised Code.

~~(C)~~ (E) "Covered policy or contract" means any policy, contract, or group certificate within the scope of section 3956.04 of the Revised Code.

~~(D)~~ (F) "Health benefit plan" means any hospital or medical expense policy or certificate, or health insuring corporation subscriber policy, contract, certificate, or agreement, or any other similar health or sickness and accident insurance policy or 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;

(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.

(G) "Impaired insurer" means a member insurer that, after November 20, 1989, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

~~(E)~~ (H) "Insolvent insurer" means a member insurer that, after November 20, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

~~(F)(1)~~ (I)(1) "Member insurer" means any insurer or health insuring corporation that holds a certificate of authority or is licensed to transact in this state any kind of insurance or health insuring corporation business for which coverage is provided under section 3956.04 of the Revised Code, and includes any insurer or health insuring corporation whose certificate of authority or license in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn after November 20, 1989.

(2) "Member insurer" does not include any of the following:

(a) ~~A health insuring corporation;~~

~~(b)~~ A fraternal benefit society;

~~(c)~~ (b) A self-insurance or joint self-insurance pool or plan of the state or any political subdivision of the state;

~~(d)~~ (c) A mutual protective association;

~~(e)~~ (d) An insurance exchange;

~~(f)~~ (e) Any person who qualifies as a "member insurer" under section 3955.01 of the Revised Code and who does not receive premiums on covered policies or contracts;

~~(g)~~ (f) Any entity similar to any of those described in divisions ~~(F)(2)(a)~~ (I)(2)(a) to ~~(f)~~ (e) of this section.

(3) "Member insurer" includes any insurer or health insuring corporation that operates any of the entities described in division ~~(F)(2)~~ (I)(2) of this section as a line of business, and not as a separate, affiliated legal entity, and otherwise qualifies as a member insurer.

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

(K) "Premiums" means amounts received on covered policies or contracts, less premiums, considerations, and deposits

returned on the policies or contracts, and less dividends and experience credits on the policies and contracts. "Premiums" does not include ~~either~~ any of the following:

(1) Any amounts in excess of ~~one~~ five million dollars received on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended;

(2) Any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 3956.04 of the Revised Code~~. Division (G)(2) of this section shall not be construed to require the exclusion, from assessable premiums, of premiums paid for coverages in excess~~, except that assessable premium shall not be reduced on account of ~~the~~ division (C)(2)(c) of section 3956.04 of the Revised Code relating to interest limitations ~~specified in division (B)(2)(c) of section 3956.04 of the Revised Code or of premiums paid for coverages in excess of the limitations with respect to any one individual, any one participant, or any one contract holder specified in division (C)(2) of section 3956.04 of the Revised Code~~or division (D)(2) of section 3956.04 of the Revised Code relating to limitations with respect to one individual, one participant, and one policy or contract owner;

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

number of policies or contracts held by the owner.

~~(H)~~ (L) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. 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 who are either residents of a foreign country or residents of a United States possession, territory, or protectorate that does not have an association similar to the association created by this chapter shall be considered residents of the state of domicile of the insurer that issued the policy or contract.

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

~~(J)~~ (N) "Subaccount" means any of the three subaccounts created under division (A) of section 3956.06 of the Revised Code.

~~(K)~~ (O) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

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

Sec. 3956.03. The purpose of this chapter is to protect,

subject to certain limitations, the persons specified in division (A) of section 3956.04 of the Revised Code against failure in the performance of contractual obligations under life ~~and~~, health ~~insurance policies~~, and annuity policies, plans, or contracts specified in division ~~(B)~~ (C) of section 3956.04 of the Revised Code, due to the impairment or insolvency of the member insurer that issued the policies, plans, or contracts. To provide this protection, the Ohio life and health insurance guaranty association, an association of member insurers, is created to pay benefits and to continue coverages, as limited in this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

Sec. 3956.04. (A) This chapter provides coverage, by the Ohio life and health insurance guaranty association, for the policies and contracts specified in division ~~(B)~~ (C) of this section to all of the following persons:

(1) Persons, regardless of where they reside, except for nonresident certificate holders or enrollees under group policies or contracts, who are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under division (A)(2) of this section~~, regardless of where they reside, except for nonresident certificate holders under group policies or contracts~~;

(2) Persons who are owners of or certificate holders or enrollees under the policies or contracts other than structured settlement annuities~~, or, in the case of~~ and unallocated annuity contracts~~, the persons who are the contract holders,~~ if either of the following applies:

(a) The persons are residents of this state~~;~~.

(b) The persons are not residents of this state and all of the following conditions apply:

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

(ii) ~~At the time the policies or contracts were issued,~~ The persons are not eligible for coverage by an association in any other state due to the fact that the ~~insurers~~ insurer or health insuring corporation did not hold a license or certificate of authority in the states in which the persons reside~~;~~ at the time specified in the state's guaranty association laws.

(iii) The states have associations similar to the association created by section 3956.06 of the Revised Code~~;~~

~~(iv) The persons are not eligible for coverage by those associations~~.

(3) Persons who are the owners of unallocated annuity contracts specified in division (C) of this section when those contracts meet either of the following criteria:

(a) The contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state.

(b) The contracts are issued to or in connection with government lotteries if the owners are residents of this state.

(4) Persons who are payees, or the beneficiary of a payee if the payee is deceased, under a structured settlement annuity if the payee is a resident of this state, regardless of where the contract owner resides;

~~(4)~~ (5) Persons who are payees, or the beneficiary of a payee if the payee is deceased, under a structured settlement annuity if the payee is not a resident of this state, but both of the following are true:

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

(b) The payee, the beneficiary, and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

~~(5) Persons who are payees or beneficiaries of a contract owner resident of this state to the extent coverage is provided under division (A)(4) of this section, unless the payee or beneficiary is afforded any coverage by the association of another state.~~

This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter receives coverage under the laws of another state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this chapter in situations in which 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.

~~(B)(1)~~ (B) This chapter shall not provide coverage to any of the following:

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

(2) A person covered under division (A)(3) of this section, if any coverage is provided by the association of another state to the person;

(3) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(C)(1) This chapter provides coverage to the persons specified in division (A) of this section for direct, nongroup life insurance, health insurance, which for the purposes of this chapter includes sickness and accident insurance policies and contracts, and health insuring corporation subscriber policies, contracts, certificates, and agreements, or ~~annuity policies or contracts~~annuities, for certificates under direct group policies and contracts, for supplemental contracts to any of the preceding, and for unallocated annuity contracts, in each case issued by member insurers, except as otherwise limited in this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(2) ~~This~~ Except as provided in division (C)(3) of this section, this chapter does not provide coverage for any of the following:

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

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

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

(i) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract or if the policy or contract has been issued for a lesser period averaged over that period, exceeds the rate of interest determined by subtracting two percentage points from the monthly average-corporates as published by Moody's investors service, inc., or any successor to that service, averaged for the same period;

(ii) On and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from the monthly average-corporates as published by Moody's investors service, inc., or any successor to that service, as most recently available.

If the monthly average-corporates is no longer published,

the superintendent, by rule, shall establish a substantially similar average.

(d) Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members 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 similar entity under any of the following:

(i) A multiple employer welfare arrangement as defined in section 3(40) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 833, 29 U.S.C.A. 1002(40), as amended;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan;

(iv) An administrative services only contract.

(e) Any portion of a policy or contract to the extent that it provides dividends<u>, voting rights,</u> or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

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

(g) Any unallocated annuity contract issued to an employee benefit plan protected under the federal pension benefit guaranty corporation<u>, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan</u>;

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

(i) ~~Any policy or contract issued to or for the benefit of a past or present director or officer within one year of the filing of the successful complaint that the insurer was impaired or insolvent~~Any portion of a policy or contract to the extent that the assessments required by section 3956.09 of the Revised Code with respect to the policy or contract are preempted by federal or state law;

(j) ~~Any policy or contract issued by any entity described in division (F)(2) of section 3956.01 of the Revised Code~~Any 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 all of the following:

(i) Claims based on marketing materials;

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

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

(iv) Extra-contractual claims;

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

(k) ~~Any policy or contract issued by a member insurer if~~

~~the member insurer is carrying on as a line of business, and not as a separate legal entity, the activities of any entity described in division (F)(2) of section 3956.01 of the Revised Code, and the policy or contract is issued as a product of those activities~~ 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) Any policy or contract providing hospital, medical, prescription drug, or other health care benefits pursuant to 42 U.S.C. Chapter 7, Title XVIII, Parts C and D or 42 U.S.C. Chapter 7, Title XIX and any corresponding regulations;

(m) Structured settlement annuity benefits to which a payee or the beneficiary of a payee, if the payee is deceased, has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective;

(n)(i) 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.

(ii) 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 division (C)(2)(n) of this section, 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.

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

~~(C)~~ (D) The benefits for which the association may become liable shall not exceed the lesser of either of the following:

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

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

(i) Three hundred thousand dollars ~~in~~ for life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(ii) One hundred thousand dollars ~~in~~ for health insurance benefits other than ~~basic hospital, medical, and surgical insurance, major medical insurance,~~ health benefit plan coverage, disability income insurance, or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(iii) Three hundred thousand dollars ~~in~~ for disability

income insurance;

(iv) Three hundred thousand dollars ~~in~~ for long-term care insurance;

(v) Five hundred thousand dollars ~~in basic hospital, medical, and surgical insurance or major medical insurance~~for health benefit plan coverage;

(vi) Two hundred fifty thousand dollars ~~in~~ for the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(b) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased, in the aggregate, two hundred fifty thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values.

The association is not liable to expend more than three hundred thousand dollars in the aggregate with respect to any one individual under divisions ~~(C)(2)(a)~~ (D)(2)(a), (b), and (d) of this section combined, except with respect to benefits for ~~basic hospital, medical, and surgical insurance and major medical insurance~~ health benefit plan coverage under division ~~(C)(2)(a)(v)~~ (D)(2)(a)(v) of this section, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual.

(c) With respect to any one contract holder, covered by any unallocated annuity contract not included in division ~~(C)(2)(b)~~ (D)(2)(b) of this section, ~~one~~ five million dollars in

benefits, irrespective of the number of ~~those~~ contracts held by that contract holder.

(d) With respect to each payee of a structured settlement annuity, or the beneficiary or beneficiaries of the payee if the payee is deceased, two hundred fifty thousand dollars in present value of annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(e)(i) The limitations set forth in this division 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.

(ii) 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.

~~(D)~~ (E) The liability of the association is limited strictly by the express terms of the policies or contracts and by this chapter, and is not affected by the contents of any brochures, illustrations, advertisements in the print or electronic media, or other advertising material used in connection with the sale of the policies or contracts, or by oral statements made by agents or other sales representatives in connection with the sale of the policies or contracts. The association is not liable for extra-contractual damages, punitive damages, attorney's fees, or interest other than as provided for by the terms of the policies or contracts as limited by this chapter, that might be awarded by any court or governmental agency in connection with the policies or

contracts.

~~(E)~~ (F) The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(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 it relates.

(H) In performing its obligations to provide coverage under section 3956.08 of the Revised Code, the association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy that do not materially affect the economic values or economic benefits of the covered policy.

Sec. 3956.06. (A) There is hereby created an unincorporated nonprofit association to be known as the Ohio life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their license or authority to transact the business of insurance or health insuring corporation business in this state. The association shall perform its functions under the plan of operation established and approved under section 3956.10 of the Revised Code and shall exercise its powers through a board of directors established under section 3956.07 of the Revised Code. For purposes of administration and assessment, the association shall maintain the following two accounts:

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

(a) Life insurance subaccount;

(b) Annuity subaccount;

(c) Unallocated annuity subaccount that also includes all annuity contracts meeting the requirements of section 403(b) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(2) The health ~~insurance~~ account.

(B) The association is subject to the supervision of the superintendent of insurance and to the applicable insurance laws of this state.

Sec. 3956.07. (A) The board of directors of the Ohio life and health insurance guaranty association shall consist of not less than nine nor more than eleven member insurers serving terms as established in the plan of operation. A majority of the members of the board shall be representatives of member insurers domiciled in this state. Three of the members of the board shall be representatives of the three member insurers ~~that are consolidated corporations as defined in division (A)(1) of section 3923.39 of the Revised Code and~~ that write the largest premium volumes of health insurance in this state, three of the members of the board shall be representatives of domestic life insurers, and three of the members of the board shall be representatives of foreign member insurers. The members of the board shall be selected by member insurers, subject to the approval of the superintendent of insurance. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the

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

(B) In approving selections or in appointing members to the board, the superintendent 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 reasonable expenses incurred by them as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

Sec. 3956.08. (A)(1) Subject to any conditions imposed as provided in division (A)(2) of this section, the Ohio life and health insurance guaranty association may do either of the following with respect to an impaired ~~domestic~~ member insurer:

(a) 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;

(b) Provide the moneys, pledges, notes, guarantees, or other means that are proper to effectuate division (A)(1)(a) of this section and assure payment of the contractual obligations of the impaired insurer pending action under division (A)(1)(a) of this section.

(2) The association may impose conditions upon any action it takes under division (A)(1) of this section if ~~all~~ both of the following apply:

(a) The condition does not impair the contractual obligations of the impaired insurer;

(b) The superintendent of insurance approves the condition~~;~~

~~(c) Except in cases of court-ordered conservation or rehabilitation, the impaired insurer approves the condition~~.

~~(B)(1) If a member insurer is an impaired foreign or alien insurer that is not paying claims timely, the association, subject to the conditions specified in division (B)(2) of this section, shall do either of the following:~~

~~(a) Take any of the actions specified in division (A)(1) of this section, subject to the conditions specified in division (A)(2) of this section;~~

~~(b) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for all of the following:~~

~~(i) Death benefits and health claims in accordance with division (D) of this section;~~

~~(ii) Periodic annuity benefit payments;~~

~~(iii) Supplemental benefits;~~

~~(iv) Cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the superintendent.~~

~~(2) The association is subject to the requirements of division (B)(1) of this section only if all of the following apply to a foreign or alien insurer:~~

~~(a) The laws of its state of domicile provide that, until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses and interest, at a rate not less than that allowed under 96 Stat. 2478, 28 U.S.C.A. 1961, on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations, all of the following apply:~~

~~(i) The delinquency proceeding shall not be dismissed.~~

~~(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management.~~

~~(iii) The impaired insurer shall not be permitted to solicit or accept new business or have any suspended or revoked license restored.~~

~~(b) The impaired insurer has been prohibited from soliciting or accepting new business in this state, its license or certificate of authority has been suspended or revoked in this state, and a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of insurance of that state.~~

~~(C)~~ (B) If a member insurer is an insolvent insurer, the association shall, at its discretion, do either of the following:

(1) Guarantee, assume, reissue, or reinsure, or cause to

be guaranteed, assumed, reissued, or reinsured, the covered policies or contracts of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer, and provide the moneys, pledges, guarantees, or other means that are reasonably necessary to discharge such duties;

(2) ~~With respect only to life and health insurance policies, provide~~ Provide benefits and coverages in accordance with division ~~(D)~~ (C) of this section.

~~(D)~~ (C) When proceeding under division ~~(B)(1)(b) or (C)(2)~~ (B)(2) of this section, the association, with respect to ~~life and health insurance~~ policies and contracts, shall do all of the following:

(1) 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 within the following time limits:

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

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

(2) Make diligent efforts to provide all known insureds, enrollees, annuitants, or group ~~policyholders~~ policy or contract

owners with respect to group policies and contracts thirty days' notice of the termination of the benefits provided;

(3) With respect to individual policies and contracts, make available to each known insured, annuitant, enrollee, or owner if other than the insured or annuitant, and with respect to an individual formerly ~~insured~~ an insured, annuitant, or enrollee 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 division ~~(D)(4)~~ (C)(4) of this section, if such insureds, annuitants, or enrollees had a right under law or the terminated policy or contract to convert coverage to individual coverage or to continue an individual policy or contract in force until a specified age or for a specified time, during which the insurer or health insuring corporation had no right unilaterally to make changes in any provision of the policy, annuity, or contract or had a right only to make changes in premium by class.

(4)(a) In providing the substitute coverage required under division ~~(D)(3)~~ (C)(3) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates.

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

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

(5)(a) Alternative policies or contracts adopted by the

association shall be subject to the approval of the superintendent. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

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

(c) 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.

(6) 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 superintendent~~ or a court of competent jurisdiction~~.

(7) The obligations of the association 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 ~~policyholder~~ policy or contract owner, the insured, the enrollee, or the association.

~~(E)~~ (D) When proceeding under ~~divisions (B)(1)(b) or (C)~~ division (B) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with division ~~(B)(2)(c)~~ (C)(2)(c) of section 3956.04 of the Revised Code.

~~(F)~~ (E) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the obligations of the association under the policy, 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 this chapter.

~~(G)~~ (F) 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, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

~~(H)~~ (G) In carrying out its duties under ~~divisions~~ division (B) ~~and (C)~~ of this section, the association, subject to approval by the court, may do the following:

(1) Impose permanent policy or contract liens in connection with any 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 the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest;

~~(2)~~ (2)(a) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value;

(b) 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.

~~(I)~~ (H) If the association fails to act as provided in divisions ~~(B)(1)(b), (C), and (D)~~ (B) and (C) of this section within a reasonable time, the superintendent shall have the powers and duties of the association under this chapter with respect to impaired or insolvent insurers.

~~(J)~~ (I) The association may render assistance and advice to the superintendent, upon ~~his~~ the superintendent's request, concerning any member insurer that is insolvent, impaired, or potentially impaired, or concerning the rehabilitation, payment

of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

~~(K)~~ (J) The association, and any similar associations of other states, may appear or intervene before any court in this state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated under this chapter, or over a third party against whom the association or associations have or may have rights through subrogation of the member insurer's policy or contract holders. The right to appear or intervene extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the covered policies or contracts of the impaired or insolvent insurer and the determination of the covered policies or contracts and contractual obligations. The association also has 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 ~~a third party~~ any person or property against whom the association may have rights through subrogation ~~of the insurer's policy or contract holders~~or otherwise.

~~(L)(1)~~ (K)(1) Any person receiving benefits under this chapter is deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received as a result 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 holder, beneficiary, insured, or annuitant as a

condition precedent to the receipt of any rights or benefits conferred by this chapter upon such person.

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

(3) In addition to divisions ~~(L)(1)~~ (K)(1) and (2) of this section, the association has 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 ~~holder of a~~ the policy or contract holder, beneficiary, enrollee, or payee with respect to the policy or contract, including, without limitation, 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 therefore, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code.

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

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to

which the association has rights as described in the preceding divisions, 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.

~~(M)~~ (L) If the aggregate liability of the association with respect to any one life does not exceed one hundred dollars, the association is not obligated to notify claimants possessing such claims or make any payment thereto.

~~(N)~~ (M) Except with respect to claims filed under policies and contracts which are continued in force by the association past the final date set by a court for filing claims in liquidation proceedings of an insolvent insurer, the association is not liable to pay any claim filed with the association after such date.

~~(O)~~ (N) The association may do any of the following:

(1) Enter into any such contracts and take such actions as are necessary or proper in the judgment of the board of directors to protect the interests of the association, or to carry out the powers and duties of the association or 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 section 3956.09 of the Revised Code and to settle 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 are legal investments for domestic insurers and may be carried as admitted assets.

(4) Employ or retain such persons as are necessary to

handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

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

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

(7) 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;

(8) 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;

(9) Enter into agreements with other state associations of similar purposes to determine the residence of persons for purposes of this chapter;

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

(11) 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.

(O)(1) A deposit in this state, held pursuant to law or required by the superintendent 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 a member insurer domiciled in this state or in a reciprocal state, shall, pursuant to Chapter 3903. of the Revised Code, be promptly paid to the association.

(2) The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this division.

(3) 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.

(P)(1)(a) At any time within one hundred eighty 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 is effective as of the date of the order of liquidation. The election shall be effected by the

association or the national organization of life and health insurance guaranty associations on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(b) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association or to the national organization of life and health insurance guaranty associations on its behalf as soon as possible after commencement of formal delinquency proceedings both of the following:

(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;

(ii) Notices of any defaults under the reinsurance contacts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(2) Divisions (P)(2)(a) to (d) of this section apply to reinsurance contracts so assumed by the association.

(a) The association is responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and is 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.

(b) The association is 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 is obliged to pay to the beneficiary under the policy, contracts, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of the following:

(i) The amount received by the association;

(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, contracts, or annuity less the retention of the insurer applicable to the loss or event.

(c) Within thirty days following the association's election, the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining balance due the other, in each case

within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association pursuant to division (P)(2)(b) of this section, the receiver shall remit the same to the association as promptly as practicable.

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

(3) During the period from the date of the order of liquidation until the election date, or, if the election date does not occur, until one hundred eighty days after the date of the order of liquidation, both of the following shall apply:

(a)(i) Neither the association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the association has the right to assume under division (P)(1) of this section, whether for periods prior to or after the date of the order of liquidation.

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

(b) Provided that the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by divisions (P)(1) and (2) of this section.

(4) If the association does not elect to assume a reinsurance contract by the election date pursuant to division (P)(1) of this section, 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.

(5) 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 division (P)(1) of this section, subject to the following:

(a) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contracts transferred do not cover any new policies of insurance, contracts, or annuities in addition to those transferred.

(b) The obligations described in division (P)(1) of this section no longer apply with respect to matters arising after the effective date of the transfer.

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

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

(7) Except as otherwise provided in this division, nothing in this division shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this division abrogates or limits any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this division gives a policy owner, 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 division limits or affects the association's rights as a creditor of the estate against the assets of the estate. Nothing in this division applies to reinsurance agreements covering property or casualty risks.

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

(R) 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 is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(S) Venue in a suit against the association arising under the chapter shall be in Franklin county. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

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

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

(a) A fixed interest rate;

(b) Payment of dividends with minimum guarantees;

(c) 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.

(3) The alternative policy or contract is substantially

similar to the replaced policy or contract in all other material terms.

Sec. 3956.09. (A) For the purpose of providing the funds necessary to carry out the powers and duties of the Ohio life and health insurance guaranty association, the board of directors shall assess the member insurers, separately for each subaccount or account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten per cent per year on and after the due date.

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

(1) Class A assessments shall be ~~made~~ authorized and called for the purpose of meeting administrative and legal costs and other expenses, and the cost of ~~examinations conducted~~ detecting and preventing member insurer insolvencies under division (E) of section 3956.12 of the Revised Code. Class A assessments may be ~~made~~ authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be ~~made~~ authorized and called to the extent necessary to carry out the powers and duties of the association under section 3956.08 of the Revised Code 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 ~~made~~ authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. ~~A non-pro rata assessment shall not exceed two hundred dollars per member insurer in any one calendar year.~~ The amount of any

class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts ~~and accounts~~ 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 on any other standard considered by the board in its sole discretion as being fair and reasonable under the circumstances.

~~(2)~~ (2)(a) The amount of the class B assessments 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 superintendent of insurance.

(b) The methodology shall provide for fifty per cent of the assessment to be allocated to sickness and accident and health member insurers and fifty per cent to be allocated to life and annuity member insurers.

(c) For the purposes of divisions (C)(2)(a) and (b) of this section:

(i) "Life and annuity member insurer" means a member insurer for which the sum of its assessable life insurance premiums and annuity premiums is greater than or equal to its assessable health insurance premiums.

(ii) "Assessable health insurance premiums" includes the member insurer's assessable sickness and accident premiums and health insuring corporation premiums, but shall exclude its assessable premiums written for disability income insurance and long-term care insurance. For purposes of this definition, assessable premiums shall be measured within the state.

(iii) "Sickness and accident and health member insurer" means any member insurer not defined as a life and annuity member insurer.

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

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be ~~made~~ authorized and called until necessary to implement the purposes of this chapter. Classification of assessments under division (B) of this section and computation of assessments under this division 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 share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(D) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which 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. In determining whether the payment of an assessment would endanger the ability of a member insurer to fulfill its contractual obligations, the board shall consider the adequacy of the capital and surplus of the member insurer in relation to the premiums written, the assets, and the reserve liabilities of that member insurer.

(E)(1) The total of all assessments upon a member insurer for the life insurance and annuity account, which includes the life insurance subaccount, the annuity subaccount, and the unallocated annuity subaccount, shall not in any one calendar year exceed two per cent of the member insurer's average premiums received per year in this state on the policies and contracts covered by each such subaccount, and for the health ~~insurance~~ account, shall not in any one calendar year exceed two per cent of the member insurer's average premiums received per year in this state on the policies and contracts covered by such account, during the three calendar years preceding the year in which the impaired or insolvent insurer or insurers became impaired or insolvent. If the maximum assessment for a subaccount or account, together with the other assets of the association in the subaccount or account, does not provide in any one year in the subaccount or account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed for the subaccount or account as soon thereafter in succeeding years as permitted by division (E) of this section.

(2) If the maximum assessment under division (E)(1) of

this section for any subaccount of the life insurance and annuity account in any succeeding year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to division ~~(C)(2)~~(C)(2)(d) of this section, the board shall ~~allocate the necessary additional amount among~~ assess the other subaccounts of the life and annuity account ~~in the manner set forth in division (E)(1) of this section, but the maximum assessment for a subaccount shall not exceed one per cent in any one calendar year~~for the necessary additional amount, subject to the maximum stated in division (E)(1) of this section.

(3) Where assessments for two or more impaired or insolvent insurers have been made within the same calendar year, and the sum of those assessments exceeds the two per cent calendar year assessment limitation under division (E)(1) of this section, the board, with the approval of the superintendent of insurance, may allocate among the accounts of such member insurers the sums assessed within the two per cent limitation.

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

(G) A member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance or health insuring corporation business within the scope of this chapter, may consider the amount reasonably necessary to meet its assessment obligations under this section.

(H) The association, upon request, shall issue to ~~an~~ a member insurer paying an assessment under this section, other than a class A assessment, a certificate of contribution, in a form approved by the superintendent, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in the form and for the amount, net of any amounts recovered through a tax offset, and for the period of time the superintendent may approve.

(I) Any member insurer that has contributed funds to pay claims of an impaired or insolvent insurer, pursuant to an agreement entered into with the superintendent and approved by the Franklin county court of common pleas during the five years preceding ~~the effective date of this section~~ November 20, 1989, or at any time following ~~the effective date of this section~~ November 20, 1989, shall receive a credit against any assessments levied pursuant to this section, whether the assessments are class A assessments or class B assessments, in the amount of the contribution.

If the amount of the credit exceeds the amount of assessments levied upon a member insurer in any one year, the balance of that credit shall be carried forward to subsequent years and will reduce the amount of future assessments until the

total amount of the credit has been applied to the future assessments.

For the purposes of this division, an impaired or insolvent member insurer is an insurer that meets the definitions set forth in section 3956.01 of the Revised Code, and any insurer or health insuring corporation that would have met these definitions, if it had been in effect at the time of such contribution.

(J) Division (I) of this section does not apply if ~~an~~ a member insurer has contributed funds pursuant to that division and has offset those contributions against its premium or franchise tax liability pursuant to any provision of the Revised Code authorizing the establishment of a plan for the distribution of voluntary contributions to pay the life, sickness and accident, or annuity claims of residents of this state that are unpaid due to the insolvency of an insolvent insurer.

(K)(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 sixty 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 thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the superintendent.

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

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

(L) 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 such a request.

Sec. 3956.10. (A)(1) The Ohio life and health insurance guaranty association shall submit to the superintendent of insurance a plan of operation and any amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments shall become effective upon the written approval of the superintendent, or unless the superintendent has not disapproved it within thirty days.

(2) If the association fails to submit a suitable plan of

operation within six months following ~~the effective date of this section~~ November 20, 1989, or if at any time after that date the association fails to submit suitable amendments to the plan, the superintendent, after notice and hearing, shall adopt reasonable rules that are necessary or advisable to effectuate the provisions of this chapter. The rules shall continue in force until modified by the superintendent or superseded by a plan submitted by the association and approved by the superintendent.

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

(C) In addition to requirements enumerated elsewhere in this chapter, the plan of operation shall do the following:

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

(2) Establish the amount and method of reimbursing members of the board of directors under section 3956.07 of the Revised Code;

(3) Establish regular places and times for meetings, including but not limited to 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 superintendent;

(6) Establish any additional procedures for assessments under section 3956.09 of the Revised Code, including, but not

limited to, allocating sums raised by assessments when two or more insolvencies occur in the same calendar year that are subject to the two per cent calendar year assessment limitation;

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

(D) The plan of operation may provide that any or all powers and duties of the association, except those under division ~~(O)(3)~~ (N)(3) of section 3956.08 and section 3956.09 of the Revised Code, are delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association, or its equivalent, in two or more states. The 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 division shall take effect only with the approval of both the board of directors and the superintendent, 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.

Sec. 3956.11. (A) The superintendent of insurance shall:

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

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its

shareholders, if any. The failure of the impaired insurer promptly to comply with the demand shall not excuse the association from the performance of its powers and duties under this chapter.

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

(B) The superintendent, after notice and hearing, may suspend or revoke the license or certificate of authority to transact ~~insurance~~ business in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation of the association. As an alternative, the superintendent may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five per cent of the unpaid assessment per month, but shall not be less than one hundred dollars per month.

(C) Any action of the board of directors or the association may be appealed to the superintendent by any member insurer if the appeal is taken within sixty days of the final action being appealed. If a member insurer is appealing an assessment, the amount assessed shall be paid to the association and be available to meet association obligations during the pendency of the appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Any final action or order of the superintendent is subject to review under Chapter 119. of the Revised Code.

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

(E) Notwithstanding section 109.02 of the Revised Code, the superintendent has sole authority to select and hire legal counsel to represent the superintendent in ~~his~~ the superintendent's role as rehabilitator or liquidator of an impaired or insolvent insurer.

Sec. 3956.12. To aid in the detection and prevention of member insurer insolvencies or impairments:

(A) The superintendent of insurance shall do all of the following:

(1) Notify the commissioners of insurance of all the other states, territories of the United States, and the District of Columbia when ~~he~~ the superintendent takes any of the following actions against a member insurer:

(a) Revocation of license;

(b) Suspension of license;

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

Notice under division (A)(1) of this section shall be mailed or delivered by electronic means to all insurance commissioners within thirty days following the action taken or the date on which the action occurs.

(2) Report to the board of directors of the Ohio life and health insurance guaranty association when ~~he~~ the superintendent has taken any of the actions set forth in division (A)(1) of

this section or has received a report from any other insurance commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) Report to the board of directors when ~~he~~ the superintendent has reasonable cause to believe, from any completed or ongoing examination of any member ~~company~~insurer, that the ~~company~~ member insurer may be an impaired or insolvent insurer;

(4) Furnish to the board of directors the national association of insurance commissioners' insurance regulatory information service (IRIS) ratios and listings of companies not included in the ratios developed by the commissioners. The board may use the information contained in this report in carrying out its duties and responsibilities under this section. The report and the information contained in the report shall be kept confidential by the members of the board of directors until such time as made public by the superintendent or other lawful authority.

(B) The superintendent may seek the advice and recommendation of the board of directors concerning any matter affecting ~~his~~ the superintendent's duties and responsibilities regarding the financial condition of member insurers and ~~companies~~ insurers or health insuring corporations seeking admission to transact ~~insurance~~ business in this state.

(C) The board of directors, upon majority vote, may make reports and recommendations to the superintendent upon any matter germane to the solvency, rehabilitation, or liquidation of any member insurer or germane to the solvency of any ~~company~~

insurer or health insuring corporation seeking to do ~~an insurance~~ business in this state. The reports and recommendations are not public records.

(D) The board of directors, upon majority vote, may notify the superintendent of any information the board possesses that indicates any member insurer may be an impaired or insolvent insurer.

(E) ~~The board of directors, upon majority vote, may request that the superintendent order an examination of any member insurer that the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the superintendent shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by the persons the superintendent designates. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. The examination report shall not be released to the board of directors of the association prior to its release to the public, but this shall not preclude the superintendent from complying with division (A) of this section. The superintendent shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the superintendent but it shall not be open to public inspection prior to the release of the examination report to the public.~~

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

~~(G) The board of directors, at the conclusion of any insurer insolvency in which the association was obligated to pay~~

~~covered claims, may prepare a report to the superintendent containing information it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by the other associations.~~

Sec. 3956.13. (A) Nothing in this chapter shall be construed to reduce the liability for unpaid assessments of the insureds or enrollees of an impaired or insolvent insurer operating under a plan with assessment liability.

(B) Records shall be kept of all resolutions adopted by the Ohio life and health guaranty association in carrying out its powers and duties under section 3956.08 of the Revised Code. The records shall be made public only upon the termination of a rehabilitation or liquidation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the member insurer, or upon the order of a court of competent jurisdiction. Nothing in this division shall limit the duty of the association to render a report of its activities under section 3956.14 of the Revised Code.

(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 or contracts, reduced by any amounts to which the association is entitled as subrogee pursuant to division ~~(L)~~ (K) of section 3956.08 of the Revised Code. Assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual

obligations of the impaired or insolvent insurer as required by this chapter. As used in this division, "assets attributable to covered policies or contracts" means that proportion of the assets that the reserves that should have been established for covered policies or contracts bear to the reserves that should have been established for all policies or contracts of insurance or health benefit plans written by the impaired or insolvent insurer.

(D)(1) As a creditor of the impaired or insolvent insurer as established in division (C) of this section and consistent with section 3903.34 of the Revised Code, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter.

(2) If the liquidator has not, within one hundred twenty days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(E)(1) Prior to the termination of any rehabilitation or liquidation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees, and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent

insurer. In this determination, consideration shall be given to the welfare of the policyholders, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until the total amount of valid claims of the association with interest on that amount at a rate not less than the rate allowed under 96 Stat. 2478, 28 U.S.C.A. 1961 for funds expended in carrying out its powers and duties under section 3956.08 of the Revised Code with respect to such member insurer have been fully recovered by the association.

~~(E)(1)~~ (F)(1) If an order for rehabilitation or liquidation of ~~an~~ a member insurer domiciled in this state has been entered, the rehabilitator or liquidator may 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 complaint for liquidation or rehabilitation, subject to the limitations of divisions ~~(E)(2)~~ (F)(2) and (4) of this section.

(2) No 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 is liable up to the amount of distributions ~~he~~ the person received. Any

person who was an affiliate that controlled the member insurer at the time the distributions were declared is liable up to the amount of distributions ~~he~~ the person would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

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

(5) If any person liable under division ~~(E)(3)~~ (F)(3) of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Sec. 3956.16. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the Ohio life and health guaranty association or its agents or employees, the board of directors or any member of the board, or the superintendent of insurance or ~~his~~ the superintendent's representatives, for any action or omission by them pursuant to the purposes and provisions of this chapter or in the performance of their powers and duties under this chapter. Immunity under this section extends to the participation in any organization of one or more other state associations of similar purposes as provided in division ~~(O)(7)~~ (N)(7) of section 3956.08 of the Revised Code, and to any such organization and its agents and employees.

Sec. 3956.18. (A)(1) No person shall make, publish,

disseminate, circulate, or place before the public, or cause 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 or television station, or in any other manner, any advertisement, announcement, or statement, written or oral, that uses the existence of the Ohio life and health insurance guaranty association for the purposes of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter.

(2) As used in division (A)(1) of this section, "person" includes but is not limited to any member insurer or any agent or affiliate of any member insurer.

(3) Division (A)(1) of this section does not apply to the association or any other entity that does not sell or solicit insurance or coverage by a health insuring corporation.

(B)(1) Within six months after ~~the effective date of this section~~ November 20, 1989, the association shall prepare a summary document, complying with division (C) of this section, describing the general purposes and current limitations of this chapter. The document shall be submitted to the superintendent of insurance for approval.

(2) On or after the sixtieth day after receiving approval under division (B)(1) of this section, no member insurer shall deliver a policy or contract ~~described in division (B)(1) of section 3956.04 of the Revised Code~~ to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy ~~or~~ owner, contract owner, or certificate holder, or the enrollee, prior to or at the time of delivery of the policy or contract~~, except if division (D) of~~

~~this section applies~~. The summary document also shall be available upon request by a policy~~ or~~ owner, contract owner, or certificate holder, or the enrollee.

(3) The distribution or delivery, or contents or interpretation of the summary document shall not be construed to mean that the policy or contract or the ~~holder of the~~ policy~~ or~~ owner, contract owner, or certificate holder, or the enrollee, is covered in the event of the impairment or insolvency of a member insurer. Failure to receive this summary document does not confer upon the ~~policyholder~~policy owner, contract ~~holder~~owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

(4) The association shall revise the summary document as amendments to this chapter may require.

(C) The summary document prepared under division (B)(1) of this section shall contain a clear and conspicuous disclaimer on its face. The superintendent shall adopt a rule establishing the form and content of the disclaimer. The disclaimer shall do all of the following:

(1) State the name and address of the Ohio life and health insurance guaranty association and of the department of insurance;

(2) Prominently warn the policy~~ or~~ owner, contract owner, or certificate holder, or the 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 this state;

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

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

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

~~(5)~~ (6) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter;

(7) Provide other information as directed by the superintendent, including sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

(D) ~~No insurer or agent may deliver a policy or contract described in division (B)(1) of section 3956.04 of the Revised Code, all or a portion of which is excluded under division (B)(2)(a) of section 3956.04 of the Revised Code from coverage under this chapter unless the insurer or agent, prior to or at the time of delivery, gives the policy orcontract holder a separate written notice that clearly and conspicuously discloses that the policy or contract, or a portion of the policy or contract, is not covered by the association. The superintendent, by rule, shall specify the form and content of the notice~~A member insurer shall retain evidence of compliance with division (B) of this section for so long as the policy or contract for which the notice is given remains in effect.

Sec. 3956.19. (A) The provisions of this chapter in effect prior to the effective date of this section shall apply to all matters relating to any impaired insurer or insolvent insurer for which the association first became obligated under section 3956.08 of the Revised Code prior to the effective date.

(B) The provisions of this chapter in effect on and after the effective date of this section shall apply to all matters relating to any impaired insurer or insolvent insurer for which the association first becomes obligated under section 3956.08 of the Revised Code on or after the effective date.

Sec. 3956.20. (A)(1) A member insurer may offset against its premium or franchise tax liability twenty per cent of the assessment described in division (H) of section 3956.09 of the Revised Code in each of the five calendar years following the fiscal biennium in which the assessment was paid. The offsets shall be allowed on a year-per-year basis commencing with the first tax payment due after the fiscal biennium in which the assessment was paid.

(2) If the aggregate total of the assessments described in division (A)(1) of this section and eligible for offset in a particular year exceeds a member insurer's tax liability to this state for such year, the aggregate total of the remaining eligible assessments, notwithstanding the five-year limitation set forth in division (A)(1) of this section, may be offset against such tax liability in future years.

(3) If a member insurer ceases doing business, all uncredited assessments may be credited against its premium or franchise tax liability for the year it ceases doing business.

(4) The Ohio life and health insurance guaranty

association may require a member insurer to report any offset to the association.

(B) A member insurer that is exempt from taxes described in division (A) of this section 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 superintendent. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, the medical 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.

(C) Any sums that are acquired by member insurers by refund from the association pursuant to division (F) of section 3956.09 of the Revised Code and that have been offset, prior to the refund, against premium or franchise tax liability as provided in division (A) of this section shall be paid by such member insurers to this state in the manner the superintendent of insurance requires. The association shall notify the superintendent that the refunds have been made.

Section 2. That existing sections 3956.01, 3956.03, 3956.04, 3956.06, 3956.07, 3956.08, 3956.09, 3956.10, 3956.11, 3956.12, 3956.13, 3956.16, 3956.18, and 3956.20 of the Revised Code are hereby repealed.

Section 3. That section 3956.19 of the Revised Code is hereby repealed.