



2020 South Dakota Legislature  
**House Bill 1018**  
**ENROLLED**

AN ACT

**ENTITLED An Act to revise certain provisions regarding life and health insurance insolvencies.**

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

**Section 1.** That § 58-29C-45 be AMENDED:

**58-29C-45. Purpose of chapter--Creation of association.**

A. The purpose of this chapter is to protect, subject to certain limitations, the persons specified in subpart A of § 58-29C-46 against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts specified in subpart B of § 58-29C-46, because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

B. To provide this protection, an association of member insurers is organized to pay benefits and to continue coverages as limited by this chapter, and members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

**Section 2.** That § 58-29C-46 be AMENDED:

**58-29C-46. Persons provided with coverage--Policies and portions of policies not covered.**

A. This chapter shall provide coverage for the policies and contracts specified in subpart B:

- (1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees, or payees of the persons covered under subdivision (2);
- (2) To persons who are owners of or certificate holders under the policies or contracts (other than structured settlement annuities) and in each case who:
  - (a) Are residents; or

- (b) Are not residents, but only under all of the following conditions:
  - (i) The member insurer that issued the policies or contracts is domiciled in this state;
  - (ii) The states in which the persons reside have associations similar to the association created by this chapter; and
  - (iii) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law;
- (3) For structured settlement annuities specified in subpart B, subdivisions (1) and (2) of this subpart do not apply, and this chapter shall (except as provided in subdivisions (4) and (5) of this subpart) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:
  - (a) Is a resident, regardless of where the contract owner resides; or
  - (b) Is not a resident, but only under both of the following conditions:
    - (i)(I) The contract owner of the structured settlement annuity is a resident, or
    - (II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this chapter; and
    - (ii) Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;
- (4) This chapter does not provide coverage to 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;
- (5) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person may not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or

assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

B. (1) This chapter shall provide coverage to the persons specified in subpart A for the policies or contracts of direct, nongroup life insurance, health insurance, or annuities, and for certificates under direct group policies and contracts, and for supplemental contracts to any of these, in each case except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(2) Except as otherwise provided in subdivision (3) of this subpart, this chapter may not provide coverage for:

- (a) A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- (b) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;
- (c) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:
  - (i) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and
  - (ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;
- (d) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is

self-funded or uninsured, including benefits payable by an employer, association, or other person under:

- (i) A multiple employer welfare arrangement as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002(40));
  - (ii) A minimum premium group insurance plan;
  - (iii) A stop-loss group insurance plan; or
  - (iv) An administrative services only contract;
- (e) A portion of a policy or contract to the extent that it provides for:
- (i) Dividends or experience rating credits;
  - (ii) Voting rights; or
  - (iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- (f) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;
- (g) A portion of a policy or contract to the extent that the assessments required by § 58-29C-52 with respect to the policy or contract are preempted by federal or state law;
- (h) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the certificate holder, contract owner or policy owner, including without limitation:
- (i) Claims based on marketing materials;
  - (ii) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;
  - (iii) Misrepresentations of or regarding policy or contract benefits;
  - (iv) Extra-contractual claims; or
  - (v) A claim for penalties or consequential or incidental damages;
- (i) 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;

- (j) An unallocated annuity contract;
  - (k) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, for purposes of determining the values that have been credited and are not subject to forfeiture under this subsection, the interest or change in value determined by using the procedures defined in the policy or contract shall 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; and
  - (l) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D), or Subchapter XIX, Chapter 7 Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto.
- (3) The exclusion from coverage under subsection (2)(c) of this subdivision does not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

C. The benefits that the association may become obligated to cover may in no event exceed the lesser of:

- (1) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or
- (2)(a) With respect to one life, regardless of the number of policies or contracts:
  - (i) Three hundred thousand dollars in 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) For health insurance benefits:
    - (I) One hundred thousand dollars for coverages not described in clauses (II) and (III) below, including any net cash surrender and net cash withdrawal values;

- (II) Three hundred thousand dollars for disability income insurance as defined in § 58-17-108, and three hundred thousand dollars for long-term care insurance as defined in subdivision 58-17B-2(6);
  - (III) Five hundred thousand dollars for health benefit plans; or
- (iii) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or
- (b) With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), two hundred fifty thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;
- (c) However, in no event may the association be obligated to cover more than
  - (i) an aggregate of three hundred thousand dollars in benefits with respect to any one life under subsections 2(a) and 2(b) of subpart C of this section except with respect to benefits for health benefit plans under subparagraph 2(a)(ii) of this section, in which case the aggregate liability of the association may not exceed five hundred thousand dollars with respect to any one individual, or
  - (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner;
- (d) The limitations set forth in this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights; and
- (e) For the purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type

of benefits as the base life insurance policy or annuity contract to which it relates.

D. In performing its obligations to provide coverage under § 58-29C-51, the association may not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

**Section 3.** That § 58-29C-48 be AMENDED:

**58-29C-48. Definitions.**

Terms used in this chapter mean:

- (1) "Account," either of the two accounts created under § 58-29C-49;
- (2) "Association," the South Dakota Life and Health Insurance Guaranty Association described in § 58-29C-49;
- (3) "Authorized assessment" or the term "authorized" when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;
- (4) "Benefit plan," a specific employee, union, or association of natural persons benefit plan;
- (5) "Called assessment" or the term "called" when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;
- (6) "Contractual obligation," an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under § 58-29C-46;
- (7) "Covered contract" or "covered policy," a policy or contract or portion of a policy or contract for which coverage is provided under § 58-29C-46;
- (8) "Extra-contractual claims," include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs;
- (9) "Health benefit plan," any hospital or medical expense policy or certificate. This

term does not include:

- (a) Accident only insurance;
  - (b) Credit insurance;
  - (c) Dental only insurance;
  - (d) Vision only insurance;
  - (e) Medicare supplement insurance;
  - (f) Benefits for long-term care, home health care, community-based care, or any combination thereof;
  - (g) Disability income insurance;
  - (h) Coverage for on-site medical clinics; or
  - (i) 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;
- (10) "Impaired insurer," a member insurer which, after July 1, 2003, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;
- (11) "Insolvent insurer," a member insurer which after July 1, 2003, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;
- (12) "Member insurer," an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under § 58-29C-46, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:
- (a) A hospital or medical service organization, whether for profit or nonprofit;
  - (b) A health maintenance organization;
  - (c) A fraternal benefit society;
  - (d) A mandatory state pooling plan;
  - (e) A mutual assessment company or other person that operates on an assessment basis;
  - (f) An insurance exchange;
  - (g) An organization engaged in the issuance of charitable gift annuities, which is described in § 58-1-16; or
  - (h) An entity similar to any of the above;
- (13) "Moody's Corporate Bond Yield Average," the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto;



- (14) "Owner" of a policy or contract, "policyholder," "policy owner," and "contract owner," the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder, and policy owner do not include persons with a mere beneficial interest in a policy or contract;
- (15) "Person," an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization;
- (16) "Premiums," amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. The term, premiums, does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under subpart B of § 58-29C-46 except that assessable premium may not be reduced on account of subsection 58-29C-46B(2)(c) relating to interest limitations and subdivision 58-29C-46C(2) relating to limitations with respect to one individual, one participant, and one policy or contract owner. Premiums do not include:
- (a) Premiums on an unallocated annuity contract; or
  - (b) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;
- (17) "Principal place of business" of a plan sponsor or a person other than a natural person, the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:
- (a) The state in which the primary executive and administrative headquarters of the entity is located;
  - (b) The state in which the principal office of the chief executive officer of the entity is located;
  - (c) The state in which the board of directors (or similar governing person or

- persons) of the entity conducts the majority of its meetings;
- (d) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;
  - (e) The state from which the management of the overall operations of the entity is directed; and
  - (f) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state is determined to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a benefit plan is determined to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, is determined to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

- (18) "Receivership court," the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer;
- (19) "Resident," a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person is its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter, are determined to be residents of the state of domicile of the member insurer that issued the policies or contracts;
- (20) "Structured settlement annuity," 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;

- (21) "State," a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate;
- (22) "Supplemental contract," a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract;
- (23) "Unallocated annuity contract," an 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 the contract or certificate.

**Section 4.** That § 58-29C-50 be AMENDED:

**58-29C-50. Board of directors--Appointment and term--Vacancies--  
Compensation.**

A. The board of directors of the association shall consist of not less than seven nor more than eleven member insurers serving terms as established in the plan of operation. The insurer members of the board shall be elected by member insurers subject to the approval of the director. 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 director.

B. In approving selections or in appointing members to the board, the director may consider whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the association for expenses incurred as members of the board of directors, but members of the board may not otherwise be compensated by the association for services rendered.

**Section 5.** That § 58-29C-51 be AMENDED:

**58-29C-51. Impaired or insolvent member—Actions authorized.**

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

- (1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer; and
- (2) Provide any moneys, pledges, loans, notes, guarantees, or other means as is proper to effectuate subdivision (1) and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1).

- B. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:
- (1)(a)(i) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or
    - (ii) Assure payment of the contractual obligations of the insolvent insurer; and
  - (b) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or
- (2) Provide benefits and coverages in accordance with the following provisions:
- (a) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:
    - (i) With respect to group policies and contracts, not later than the earlier of the next renewal date under those 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 the policies and contracts;
    - (ii) With respect to nongroup policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the 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 the policies or contracts;
  - (b) Make diligent efforts to provide all known insureds or annuitants (for nongroup policies and contracts), or group policy or contract owners with respect to group policies and contracts, thirty days notice of the termination (pursuant to subsection (a) of this subdivision) of the benefits provided;
  - (c) With respect to nongroup policies and contracts covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (d), if the insureds or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue

- an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;
- (d)(i) In providing the substitute coverage required under subsection (c), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at the actuarially justified rates subject to prior approval of the director;
- (ii) Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and may not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract;
- (iii) The association may reinsure any alternative or reissued policy or contract;
- (e)(i) Alternative policies or contracts adopted by the association are subject to the approval of the director. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency;
- (ii) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy or contract was last underwritten;
- (iii) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;
- (f) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the director;

- (g) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, or the association;
- (h) When proceeding under subdivision B(2) with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subsection 58-29C-46(B)(2)(c).

C. 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 association's obligations 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 which may be due in accordance with the provisions of this chapter.

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

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

F. In carrying out its duties under subpart B, the association may:

- (1) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions affecting member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;
- (2) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a

temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in this state, held pursuant to law or required by the director 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, pursuant to §§ 58-29B-144 and 58-29B-149, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount paid to the association less the amount retained pursuant to this subpart. Any amount paid to the association and retained by the association shall be treated as a distribution of estate assets pursuant to § 58-29B-98 or similar provision of the state of domicile of the impaired or insolvent insurer.

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

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

J. The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, reissuing, modifying, or guaranteeing the

policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association 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 any person or property against whom the association may have rights through subrogation or otherwise.

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

- (2) The subrogation rights of the association under this subpart 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 subdivisions (1) and (2) of this subpart, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts.
- (4) If the preceding provisions of this subpart 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 subdivisions of this subpart, the person shall pay to the association the portion of the recovery attributable to the policies or contracts (or portion thereof) covered by the association.

L. In addition to the rights and powers elsewhere in this chapter, the association may:

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



- (2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 58-29C-52 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 member insurers and may be carried as admitted assets;
- (4) Employ or retain any persons as necessary or appropriate to handle the financial transactions of the association, and to perform other functions as become necessary or proper under this chapter;
- (5) Take legal action as may be necessary or appropriate to avoid or recover payment of improper claims;
- (6) Exercise, for the purposes of this chapter and to the extent approved by the director, the powers of a domestic life insurer or health insurer, but in no case may the association issue policies or contracts other than those issued to perform its obligations under this chapter;
- (7) Organize the association as a corporation or in other legal form permitted by the laws of the state;
- (8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request;
- (9) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which the association provides coverage under this chapter; and
- (10) Take other necessary or appropriate action to discharge the duties and obligations of the association as provided in this chapter or to exercise its powers under this chapter.

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

N. (1)(a) At any time within 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 election shall be effective as of the date of the order of liquidation. The election shall be effected

by the association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

- (b) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings:
  - (i) Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether contracts should be assumed; and
  - (ii) Notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.
- (c) Subparagraphs (i) to (iv) apply to reinsurance contracts so assumed by the association:
  - (i) 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;
  - (ii) 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 amounts, the association is obliged to pay to the beneficiary under the policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:
    - (A) The amount received by the association; and

- (B) The excess of the amount received by the association, over the amount equal to the benefits paid by the association on account of the policy, contract, or annuity less the retention of the insurer applicable to the loss or event.
- (iii) Within thirty days following the association's election (the "election date"), the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association pursuant to subparagraph (1)(c)(ii), the receiver shall remit the amounts to the association as promptly as practicable.
- (iv) 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 may not 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 may not set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due the association.

- (2) During the period from the date of the order of liquidation until the election date (or, if the election date does not occur, until one hundred eighty days after the date of the order of liquidation);
  - (a)(i) Neither the association nor the reinsurer has any rights or obligations under reinsurance contracts that the association has the right to assume under subdivision (1), whether for periods prior to or after the date of the order of liquidation; and
    - (ii) The reinsurer, the receiver, and the association shall, to the extent practicable, provide each other data and records reasonably requested;
  - (b) Provided that once the association elects to assume a reinsurance contract, the parties' rights and obligations shall be governed by subdivision (1).
- (3) If the association does not elect to assume a reinsurance contract by the election date pursuant to subdivision (1), the association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.
- (4) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the association, in the case of contracts assumed under subdivision (1), subject to the following:
  - (a) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred may not cover any new policies of insurance or annuities in addition to those transferred;
  - (b) The obligations described in subdivision (1) of this section no longer apply with respect to matters arising after the effective date of the transfer; and
  - (c) The transferring party shall give notice in writing, return receipt requested, to the affected reinsurer not less than thirty days prior to the effective date of the transfer;
- (5) The provisions of subpart N 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 remains 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; and

(6) Except as otherwise provided in this section, nothing in subpart N alters or modifies the terms and conditions of any reinsurance contract. Nothing in this section abrogates or limits any rights of any reinsurer to claim that the reinsurer is entitled to rescind a reinsurance contract. Nothing in this section gives a policyholder, policy owner, contract owner, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. No provision in this section limits or affects the association's rights as a creditor of the estate against the assets of the estate. No provision in this section applies to reinsurance agreements covering property or casualty risks.

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

P. If 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.

Q. Venue in a suit against the association arising under the chapter is in Hughes County. The association may not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

R. In carrying out the association's duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subpart 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 (i) a fixed interest rate or (ii) payment of dividends with minimum guarantees or (iii) different methods for calculating interest or changes in value;
- (2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and
- (3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

**Section 6.** That § 58-29C-52 be AMENDED:

**58-29C-52. Funding provided by assessment of members--Classification of assessments--Amounts of assessments--Abatements--Refunds.**

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

B. There are two classes of assessments, as follows:

- (1) Class A assessments are authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.
- (2) Class B assessments are authorized and called to the extent necessary to carry out the powers and duties of the association under § 58-29C-51 with regard to an impaired or an insolvent insurer.

C. (1) The amount of a Class A assessment shall be determined by the board and may be 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.

- (2) The amount of a Class B assessment, except for assessments related to long-term care insurance shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard the board in its sole discretion determines is fair and reasonable under the circumstances.
- (3) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the association's plan of operation and approved by the director. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.
- (4) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became insolvent (or, in the case

of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired) bears to premiums received on business in this state for those calendar years by all assessed member insurers.

- (5) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subpart B and computation of assessments under this subpart 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 the member insurer's 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. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

E. (1)(a) Subject to the provisions of subsection (b) of this subdivision, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account may not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

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

- (c) If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.
- (2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.
- (3) If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision C(4), the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (1) of this section.

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

G. It is proper for any member insurer, in determining the member insurer's premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet the member insurer's assessment obligations under this chapter.

H. The association shall issue to each member insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the director, for the amount of the assessment paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. The member insurer in its financial statement may show a certificate of contribution as an asset in the form, amount, and period of time as approved by the director.

I. (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment is 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 the association's 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 director.
- (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 director 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.

J. The association may request information of member insurers in order to aid in the exercise of the association's power under this section and member insurers shall promptly comply with a request.

**Section 7.** That § 58-29C-55 be AMENDED:

**58-29C-55. Detection and prevention of insurer insolvencies or impairments--Reports by board.**

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

- A. It is the duty of the director:
  - (1) To notify the directors of all the other states, territories of the United States and the District of Columbia within thirty days following the action taken or the date the action occurs, when the director takes any of the following actions against a member insurer:
    - (a) Revocation of license;
    - (b) Suspension of license; or
    - (c) Makes a formal order that the member insurer restrict its premium writing,

obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of the member insurer's business, or increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders, or creditors.

- (2) To report to the board of directors when the director has taken any of the actions set forth in subdivision (1) or has received a report from any other director indicating that any 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 director.
- (3) To report to the board of directors when the director has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.
- (4) To furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out the board's duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until the report is made public by the director or other lawful authority.

B. The director may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the director regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

C. The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do insurance business in this state. The reports and recommendations are not public documents.

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

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

**Section 8.** That § 58-29C-57 be AMENDED:

**58-29C-57. Liability for unpaid assessment--Records of meetings--  
Association as creditor of impaired or insolvent insurer--Liquidation,  
rehabilitation, or conservation proceedings.**

A. This chapter may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out the board's powers and duties under § 58-29C-51. The records of the association with respect to an impaired or insolvent insurer may not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except (i) upon the termination of the impairment or insolvency of the insurer, or (ii) upon the order of a court of competent jurisdiction. Nothing in this subpart limits the duty of the association to render a report of its activities under § 58-29C-58.

C. For the purpose of carrying out the association's obligations under this chapter, the association is a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subpart § 58-29C-51K. Assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies or contracts, as used in this subpart, are that proportion of the assets which the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

D. As a creditor of the impaired or insolvent insurer as established in subpart C of this section and consistent with § 58-29B-98, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse the association, as a credit against contractual obligations under this chapter. 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, the association is entitled to make application to the receivership court for approval of the association's own proposal to disburse these assets.

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

(2) An impaired or insolvent insurer may not make a distribution to stockholders until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out the association's powers and duties under § 58-29C-51 with respect to the member insurer have been fully recovered by the association.

F. (1) If an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under the order has a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subdivisions (2) to (4), inclusive.

(2) No distribution is 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 the member insurer's 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 received. Any person, who was an affiliate that controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if the distributions had been paid immediately. If two or more persons are liable with respect to the same distributions, the persons shall be jointly and severally liable.

(4) The maximum amount recoverable under this subpart is 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 subdivision (3) is insolvent, all the member insurer's affiliates that controlled the member insurer at the time the distribution was paid,

shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

**Section 9.** That § 58-29C-62 be AMENDED:

**58-29C-62. Use of existence of association for sales, solicitation, or inducement to purchase insurance prohibited--Summary document of purposes and limitations of chapter--Disclaimer.**

A. No person, including a member insurer, agent, or affiliate of a member insurer may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the Life and Health Insurance Guaranty Association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the South Dakota Life and Health Insurance Guaranty Association chapter. However, this section does not apply to the South Dakota Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance.

B. Within one hundred eighty days of July 1, 2003, the association shall prepare a summary document describing the general purposes and current limitations of the chapter and complying with subpart C of this section. This document shall be submitted to the director for approval. At the expiration of the sixtieth day after the date on which the director approves the document, a member insurer may not deliver a policy or contract to a policy owner, contract owner, or certificate owner unless the summary document is delivered to the policy owner, contract owner, or certificate holder at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, or certificate holder. The distribution, delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, or certificate holder is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, or insured any greater rights than those stated in this chapter.

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

- (1) State the name and address of the Life and Health Insurance Guaranty Association and insurance department;
- (2) Prominently warn the policy owner, contract owner, or certificate holder that the Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it shall 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 the member insurer's agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;
- (5) State that the policy owner, contract owner, or certificate holder should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer;
- (6) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and
- (7) Provide other information as directed by the director 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. A member insurer shall retain evidence of compliance with subpart B as long as the policy or contract for which the notice is given remains in effect.

**Section 10.** That a NEW SECTION be added:

**58-41-52.1. Collection for covered services prohibited.**

Except for coinsurance, deductibles, or copayments as specifically provided in the evidence of coverage, in no event, including nonpayment by the health maintenance organization, insolvency of the health maintenance organization, or breach of contract among the health maintenance organization, risk bearing entity, or participating provider, may a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person other than the health maintenance organization acting on behalf of

the enrollee for covered services provided. No risk bearing entity or participating provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against an enrollee to collect sums owed by the health maintenance organization.

**Section 11.** That a NEW SECTION be added:

**58-41-52.2. Contracts--Hold harmless provision.**

All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for enrollees consistent with §§ 58-41-52.1 to 58-41-52.3, inclusive. Any attempted waiver or amendment in a manner materially adverse to the interests of enrollees of a hold harmless provision are null and void and unenforceable. Any violation of the provisions of this section constitutes an unfair trade practice under chapter 58-33.

**Section 12.** That a NEW SECTION be added:

**58-41-52.3. Hold harmless provision--Language of provision.**

The requirements of § 58-41-52.2 shall be met by including a provision substantially similar to the following:

Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, may the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the enrollee for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to enrollees.

**Section 13.** That § 58-41-26 be AMENDED:

**58-41-26. Exemption from insurance laws--Exceptions--Taxation.**

Any health maintenance organization is exempt from all provisions of the insurance laws of this state other than this chapter. However, the corporation is subject to the

provisions of this title on matters and procedures of mergers and licensure of insurance producers. The corporation is also subject to fees and taxation as insurers under § 58-2-29 and chapter 10-44. The corporation is also subject to §§ 58-17-53 and 58-17-54 if entering into a contract after July 1, 1990, with the State of South Dakota, counties, school districts, municipalities, and any other unit of state government using public funds. The state, however, may not collect premium taxes for insurance written on individuals residing outside this state or property located outside this state if no comparable tax is paid by the direct writing health maintenance organization to any appropriate taxing authority. Health maintenance organizations are also subject to the following chapters: 58-1, 58-2, 58-3, 58-4, 58-5, 58-5A, 58-6, 58-7, 58-11, 58-12, 58-14, 58-17, 58-17A, 58-17F, 58-17G, 58-17H, 58-17I, 58-18, 58-18A, 58-18B, 58-18C, 58-26, 58-27, 58-29B on the same basis as insurers, 58-30, 58-33A; and 58-43. Nothing in chapters 58-5 or 58-6 may be construed to prohibit a nonprofit health maintenance organization from transacting business under this title based upon its nonprofit status.

To the extent that a health maintenance organization is compliant with the provisions of chapters 58-17F to 58-17I, inclusive, for purposes of network adequacy, quality assessment and improvements, utilization review and benefit determinations, and grievance procedure, the health maintenance organization is compliant with the provisions of this chapter.



An Act to revise certain provisions regarding life and health insurance insolvencies.

\_\_\_\_\_

I certify that the attached Act originated in  
the:

House as Bill No. 1018

\_\_\_\_\_

Received at this Executive Office  
this \_\_\_\_ day of \_\_\_\_\_,  
2020 at \_\_\_\_\_ M.

\_\_\_\_\_ Chief Clerk

By \_\_\_\_\_  
for the Governor

\_\_\_\_\_ Speaker of the House

The attached Act is hereby  
approved this \_\_\_\_\_ day of  
\_\_\_\_\_, A.D., 2020

Attest:

\_\_\_\_\_ Chief Clerk

\_\_\_\_\_ Governor

**STATE OF SOUTH DAKOTA,**

ss.

Office of the Secretary of State

\_\_\_\_\_ President of the Senate

Attest:

Filed \_\_\_\_\_, 2020  
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\_\_\_\_\_ Secretary of the Senate

\_\_\_\_\_ Secretary of State

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File No. \_\_\_\_\_  
Chapter No. \_\_\_\_\_

By \_\_\_\_\_  
Asst. Secretary of State