Part 1
Utah Life and Health Insurance Guaranty Association Act

31A-28-101 Title.

This part is known as the "Utah Life and Health Insurance Guaranty Association Act."

Amended by Chapter 185, 2002 General Session

31A-28-102 Purpose.

(1) The purpose of this part is to protect, subject to certain limitations, the persons specified in Subsections 31A-28-103(1) through (5) against failure in the performance of contractual obligations, under a life insurance, accident and health insurance, or annuity policy or contract specified in Subsections 31A-28-103(6) and (7), because of the impairment or insolvency of the member insurer that issued the policy or contract.

(2) To provide the protection described in Subsection (1):

(a) the Utah Life and Health Insurance Guaranty Association, which currently exists, is continued to pay benefits and to continue coverages as limited by this part; and

(b) members of the association are subject to assessment to provide funds to carry out the purpose of this part.

Amended by Chapter 391, 2018 General Session

31A-28-103 Coverage and limitations.

(1) This part provides coverage for a policy or contract specified in Subsections (6) and (7) to a person who is:

(a) except for a nonresident certificate holder under a group policy or contract, a beneficiary, assignee, or payee of a person covered by Subsection (1)(b), including a health care provider rendering services covered under an accident and health insurance policy or certificate, regardless of where that person resides; or

(b) an owner of or a certificate holder or enrollee under a policy or contract, other than an unallocated annuity contract or structured settlement annuity, if the owner, enrollee, or certificate holder is:

(i) a resident of Utah; or

(ii) not a resident of Utah, but only if:

(A) the member insurer that issued the policy or contract is domiciled in this state;

(B) the state in which the person resides has an association similar to the association created by this part; and

(C) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the other states at the time specified in the other states' guaranty association's laws.

(2) For an unallocated annuity contract specified in Subsections (6) and (7):

(a) Subsection (1) does not apply; and

(b) except as provided in Subsections (4) and (5), this part provides coverage for the unallocated annuity contract specified in Subsection (2) to a person who is:

(i) the owner of the unallocated annuity contract if the contract is issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; or

(ii) an owner of an unallocated annuity contract issued to or in connection with a government lottery if the owner is a resident.

(3) For a structured settlement annuity specified in Subsections (6) and (7):

(a) Subsection (1) does not apply; and

(b) except as provided in Subsections (4) and (5), this part provides coverage for the structured settlement annuity specified in Subsections (6) and (7) 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:

(i) is a resident, regardless of where the contract owner resides;

(ii) is not a resident, but only if one or more of the contract owners of the structured settlement annuity is a resident, and the payee, beneficiary, or contract owner is not eligible for coverage by the association of the state in which the payee or contract owner resides; or

(iii) is not a resident, but only if:

(A) no contract owner of the structured settlement annuity is a resident;

(B) the insurer that issued the structured settlement annuity is domiciled in this state;

(C) the state in which the contract owner resides has an association similar to the association created by this part; and

(D) the payee, beneficiary, or the contract owner is not eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) This part may not provide coverage for a policy or contract specified in Subsections (6) and (7) to a person who:

(a) 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;

(b) is covered under Subsection (2), if any coverage is provided to the person by the association of another state; or

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

(5)

(a) This part provides coverage for a policy or contract specified in Subsections (6) and (7) to a person who is a resident of this state and, in special circumstances, to a nonresident.

(b) To avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person may not be provided coverage under this part.

(c) In determining the application of this Subsection (5) when a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one association.

(6)

(a) Except as limited by this part, this part provides coverage to a person specified in Subsections (1) through (5) for:

(i) a direct nongroup life insurance, direct accident and health insurance, or direct annuity policy or contract;

(ii) a supplemental contract to a policy or contract described in Subsection (6)(a)(i);

(iii) a certificate under a direct group policy or contract; and

(iv) an unallocated annuity contract issued by a member insurer.

(b) For purposes of Subsection (6)(a), an annuity contract and a certificate under a group annuity contract includes:

(i) a guaranteed investment contract;

(ii) a deposit administration contract;
(iii) an unallocated funding agreement;
(iv) an allocated funding agreement;
(v) a structured settlement annuity;
(vi) an annuity issued to or in connection with a government lottery; and
(vii) an immediate or deferred annuity contract.

(7) This part does not provide coverage for:
(a) a portion of a policy or contract:
(i) not guaranteed by the member insurer; or
(ii) under which the risk is borne by the policy or contract owner;
(b) a policy or contract of reinsurance, unless:
(i) an assumption certificate is issued before the coverage date;
(ii) the assumption certificate required by Subsection (7)(b)(i) is in effect pursuant to the reinsurance policy or contract; and
(iii) the reinsurance contract is approved by the appropriate regulatory authorities;
(c) except as provided in Subsection (11)(e), a portion of a policy or contract to the extent that the rate of interest on which the policy or contract 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 exceeds:
(i) a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged:
(A) over the period of four years before the coverage date with respect to the policy or contract; or
(B) for the corresponding lesser period if the policy or contract was issued less than four years before the association became obligated; or
(ii) a rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available as determined on or after the earlier of:
(A) the day on which the member insurer becomes an impaired insurer; or
(B) the day on which the member insurer becomes an insolvent insurer;
(d) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, accident and 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 that term is defined in 29 U.S.C. Sec. 1002;
(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:
(i) a dividend;
(ii) an experience rating credit;
(iii) voting rights; or
(iv) payment of a fee or allowance to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
(f) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payment with respect to the benefit plan;
(g) a portion of an unallocated annuity contract that is not issued to or in connection with:

(i) a specific benefit plan of:
(A) employees;
(B) a union; or
(C) an association of natural persons; or
(ii) a government lottery;
(h) a portion of a policy or contract to the extent that the assessment required by Section 31A-28-109 that applies to the policy or contract is preempted by federal or state law;
(i) an obligation that does not arise under the express written terms of the policy or contract issued by a member insurer to the enrollee, certificate holder, contract owner, or policy owner, including:
(i) a claim based on marketing materials;
(ii) a claim based on a side letter, rider, or other document that is issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;
(iii) a misrepresentation regarding a policy or contract benefit;
(iv) an extra-contractual claim;
(v) a claim for penalties; or
(vi) a claim for consequential or incidental damages;
(j) a contract 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 a person that is:
(i)
(A) the benefit plan; or
(B) the benefit plan's trustee; and
(ii) not an affiliate of the member insurer;
(k) a portion of a policy or contract to the extent it provides for interest or other changes in value:
(i) to be determined by the use of an index or other external reference stated in the policy or contract; and
(ii) as of the date the member insurer becomes an impaired or insolvent insurer, whichever occurs earlier:
(A) that have not been credited to the policy or contract; or
(B) as to which the policy or contract owner's rights are subject to forfeiture;
(l) a policy or contract offering hospital, medical, prescription drug, or other health care benefit pursuant to:
(i) Part C or D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.;
(ii) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq.; or
(iii) Title XXI of the Social Security Act, 42 U.S.C. Sec. 1397aa et seq.; or
(m) a structured settlement annuity benefit to which a payee or beneficiary has transferred the payee or beneficiary's rights in a structured settlement factoring transaction, regardless of whether the transaction occurred before or after 26 U.S.C. Sec. 5891(c)(3)(A) became effective.
(8) The benefits for which the association may become liable may not exceed the lesser of:
(a) the contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer;
(b) with respect to one life, regardless of the number of policies or contracts:
(i) for a life insurance policy:
(A) if the insured died before the coverage date, $500,000 of the death benefit;

(B) if the insurer received a valid request for cash surrender before the coverage date but has not paid the cash surrender value before the coverage date, $200,000 of cash surrender benefits; or

(C) if neither Subsection (8)(b)(i)(A) nor (B) applies, the covered portion of each benefit provided under the policy;

(ii) for an annuity contract, the covered portion of each benefit provided under the contract; and

(iii) for an accident and health insurance policy or contract:

(A) classified as a health benefit plan, $500,000; or

(B) not classified as a health benefit plan, the covered portion of each benefit provided under the policy;

(c) for an individual participating in a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code, covered by an unallocated annuity contract, or a beneficiary of that individual if the individual is deceased, $250,000 in present value of annuity benefits, in the aggregate, including:

(i) net cash surrender; and

(ii) net cash withdrawal values; or

(d) for a payee of a structured settlement annuity or a beneficiary of the payee if the payee is deceased, the limits set forth in Subsection (8)(b).

(9) Notwithstanding Subsection (8), the association may not be obligated to cover more than:

(a) an aggregate of $500,000 in benefits for any one life under:

(i) Subsection (8)(b)(i)(A);

(ii) Subsection (8)(b)(i)(B);

(iii) Subsection (8)(b)(ii); and

(iv) Subsection (8)(b)(iii)(B);

(b) $5,000,000 in benefits for one owner of multiple nongroup policies of life insurance:

(i) whether the policy or contract owner is an individual, firm, corporation, or other person;

(ii) whether the persons insured are officers, managers, employees, or other persons; and

(iii) regardless of the number of policies and contracts held by the owner; and

(c) $5,000,000 in benefits, regardless of the number of contracts held by the contract owner or plan sponsor, for:

(i) one contract owner provided coverage under Subsection (2)(b)(ii); or

(ii) one plan sponsor whose plans own, directly or in trust, one or more unallocated annuity contracts not included in Subsection (8)(b)(ii).

(10)

(a) Notwithstanding Subsection (9)(c) and except as provided in Subsection (10)(b), the association shall provide coverage if one or more unallocated annuity contracts are:

(i) covered contracts under this part;

(ii) owned by a trust or other entity for the benefit of two or more plan sponsors; and

(iii) the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in the state.

(b) The association may not be obligated to cover more than $5,000,000 in benefits with respect to the unallocated contracts described in Subsection (10)(a).

(11)

(a) The limitations set forth in Subsections (8) and (9) are limitations on the benefits for which the association is obligated before taking into account:

(i) the association's subrogation and assignment rights; or

(ii) the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies.

(b) The costs of the association's obligations under this part may be met by the use of assets:
(i) attributable to covered policies, as described in Subsection 31A-28-114(3)(c); or
(ii) reimbursed to the association pursuant to the association's subrogation and assignment rights.
(c) 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 the long-term care rider relates.
(d) In performing the association's obligations to provide coverage under Section 31A-28-108, the association may not be required to guarantee, assume, reinsure, reissue, perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed a contractual obligation of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract.
(e) The exclusion from coverage described in Subsection (7)(c) does not apply to any portion of a policy or contract, including a rider, that offers long-term care or any other accident and health insurance benefit.

Amended by Chapter 252, 2021 General Session

31A-28-104 Construction.

This part shall be construed to effect the purposes under Section 31A-28-102.

Amended by Chapter 161, 2001 General Session

31A-28-105 Definitions.

As used in this part:
(1) "Association" means the Utah Life and Health Insurance Guaranty Association continued under Section 31A-28-106.
(2)
(a) "Authorized assessment" or "authorized," when used in the context of assessments, means that the board of directors passed a resolution by which an assessment will be called immediately or in the future from member insurers for an amount specified in the resolution.
(b) An assessment is authorized when the resolution is passed.
(3) "Benefit plan" means a specific benefit plan of:
(a) employees;
(b) a union; or
(c) an association of natural persons.
(4) "Board of directors" means the board of directors established under Section 31A-28-107.
(5)
(a) "Called assessment" or "called," when used in the context of assessments, means that the association issued a notice to member insurers requiring that an authorized assessment be paid within the time frame set forth in the notice.
(b) All or part of an authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.
(6) "Cash surrender value" means the cash surrender value without reduction for an outstanding policy loan or surrender charge.
(7) "Contractual obligation" means an obligation under any of the following for which coverage is provided under Section 31A-28-103:
(a) a policy or contract;

(b) a certificate under a group policy or contract; or
(c) a portion of a policy or contract.
(8) "Coverage date" means the date on which the association becomes responsible for the obligations of a member insurer.
(9) "Covered policy" or "covered contract" means any of the following for which coverage is provided in Section 31A-28-103:
(a) a policy or contract; or
(b) a portion of a policy or contract.
(10)
(a) "Covered portion" means:
(i) for a covered policy that has a cash surrender value, a fraction calculated with:
(A) the numerator being the lesser of:
(I)
(Aa) $200,000 for a life insurance policy; or
(Bb) $250,000 for a covered policy that is not a life insurance policy; or
(II) the cash surrender value of the policy; and
(B) the denominator being the cash surrender value of the policy; and
(ii) for a covered policy that does not have a cash surrender value, a fraction calculated with:
(A) the numerator being the lesser of:
(I)
(Aa) $200,000 for a life insurance policy; and
(Bb) $250,000 for a covered policy that is not a life insurance policy; or
(II) the policy's minimum statutory reserve; and
(B) the denominator being the policy's minimum statutory reserve.
(b) For purposes of this Subsection (10)(b), the cash surrender value and the minimum statutory reserve are determined as of the coverage date in accordance with the exclusions in Subsection 31A-28-103(7)(c).
(11) "Extra-contractual claim" includes a claim relating to:
(a) bad faith in the payment of a claim;
(b) punitive or exemplary damages; or
(c) attorney fees and costs.
(12) "Impaired insurer" means a member insurer that is not an insolvent insurer and:
(a) is considered by the commissioner to be hazardous pursuant to this title; or
(b) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
(13) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.
(14)
(a) "Member insurer" means an insurer that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 31A-28-103.
(b) "Member insurer" includes an insurer whose license or certificate of authority in this state may have been:
(i) suspended;
(ii) revoked;
(iii) not renewed; or
(iv) voluntarily withdrawn.
(c) "Member insurer" does not include:
(i) a for-profit or nonprofit:
(A) hospital;

(B) hospital service organization; or
(C) medical service organization;
(ii) a fraternal benefit society;
(iii) a mandatory state pooling plan;
(iv) a mutual assessment company or other person that operates on an assessment basis;
(v) an insurance exchange;
(vi) an organization described in Subsection 31A-22-1305(2); or
(vii) an entity similar to an entity described in Subsections (14)(c)(i) through (vi).

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

(16)
(a) "Owner" of a policy or contract, "policyholder," "policy owner," or "contract owner" means a person who:
(i) is identified as the legal owner under the terms of the policy or contract; or
(ii) is otherwise vested with legal title to the policy or contract through a valid assignment:
(A) completed in accordance with the terms of the policy or contract; and
(B) properly recorded as the owner on the books of the insurer.
(b) "Owner," "policyholder," "policy owner," or "contract owner" does not include a person with only a beneficial interest in a policy or contract.

(17)
(a) Notwithstanding Section 31A-1-301, "premiums" means an amount or consideration received on covered policies or contracts, less:
(i) returned:
(A) premiums;
(B) considerations; and
(C) deposits; and
(ii) dividends and experience credits.
(b)
(i) "Premiums" does not include an amount or consideration received for:
(A) a policy or contract for which coverage is not provided under Subsections 31A-28-103(6) and (7); or
(B) the portion of a policy or contract for which coverage is not provided under Subsections 31A-28-103(6) and (7).
(ii) Notwithstanding Subsection (17)(b)(i), an assessable premium may not be reduced on account of:
(A) Subsection 31A-28-103(7)(c) relating to interest limitations; or
(B) Subsection 31A-28-103(8) relating to limitations for:
(I) one individual;
(II) any one participant; or
(III) any one policy or contract owner.
(c) "Premiums" does not include premiums in excess of $5,000,000:
(i) on an unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code; or
(ii) for multiple nongroup policies of life insurance owned by one owner:
(A) whether the policy or contract owner is an individual, firm, corporation, or other person;
(B) whether the persons insured are officers, managers, employees, or other persons; and
(C) regardless of the number of policies or contracts held by the owner.

(18)
(a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state:
(i) 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 the function; and
(ii) 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 are 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, 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 factors described in Subsections (18)(a)(ii)(A) through (E).
(b) Notwithstanding Subsection (18)(a), in the case of a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, the state where more than 50% of the participants are employed is considered to be the principal place of business of the plan sponsor.
(c)
(i) The principal place of business of a plan sponsor of a benefit plan is considered 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.
(ii) If there is not a specific or clear designation of a principal place of business under Subsection (18)(c)(i) for a benefit plan, the principal place of business is considered to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan.
(19) "Receiver" means, as the context requires:
(a) a rehabilitator;
(b) a liquidator;
(c) an ancillary receiver; or
(d) a conservator.
(20) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.
(21)
(a) "Resident" means a person:
(i) to whom a contractual obligation is owed; and
(ii) who resides in this state on the earlier of the date a member insurer is an:
(A) impaired insurer; or
(B) insolvent insurer.
(b) A person may be a resident of only one state, which in the case of a person other than a natural person is where its principal place of business is located.

(c) A citizen of the United States that is either a resident of a foreign country or a resident of a United States possession, territory, or protectorate that does not have an association similar to the association created by this part, is considered a resident of the state of domicile of the member insurer that issued the policy or contract.

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

(23) "Structured settlement factoring transaction" means the same as that term is defined in 26 U.S.C. Sec. 5891(c)(3)(A).

(24) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a policy or contract for:

(a) life insurance;

(b) accident and health insurance; or

(c) annuity.

(25) "Unallocated annuity contract" means 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.

Amended by Chapter 391, 2018 General Session

31A-28-106 Continuation of the association -- Association duties -- Allocation of assessments -- Not agency of state.

(1)

(a) There is continued under this part the nonprofit legal entity known as the Utah Life and Health Insurance Guaranty Association created under former provisions of this title.

(b) All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state.

(c) The association shall:

(i) perform its functions under the plan of operation established and approved under Section 31A-28-110; and

(ii) exercise the association's powers through the board of directors.

(d) The association shall allocate assessments among the following classes or subclasses:

(i) the life insurance and annuity class, which includes the following subclasses:

(A) the life insurance subclass;

(B) the annuity subclass:

(I) which includes annuity contracts owned by a governmental retirement plan, or its trustee, established under Section 401, 403(b), or 457, Internal Revenue Code; and

(II) otherwise excludes unallocated annuities; and

(C) the unallocated annuity subclass, which excludes contracts owned by a governmental retirement benefit plan, or its trustee, established under Sections 401, 403(b), or 457, Internal Revenue Code; and

(ii) the accident and health insurance class.

(2)

(a) The association shall:

(i) come under the immediate supervision of the commissioner; and

(ii) be subject to the applicable provisions of the insurance laws of this state.

(b) Meetings or records of the association may be opened to the public upon majority vote of the board of directors.

(3) The association is not an agency of the state.

Amended by Chapter 391, 2018 General Session

31A-28-107 Board of directors.

(1)

(a) The board of directors of the association shall consist of:

(i) at least seven but not more than eleven member insurers who:

(A) serve terms as established in the plan of operation; and

(B) are selected by member insurers, subject to the approval of the commissioner; and

(ii) two public representatives appointed by the commissioner.

(b)

(i) The commissioner shall make the appointment of a public representative coincide with the association's annual meeting at which the association's board of directors is elected.

(ii) A public representative may not be:

(A) an officer, director, or employee of an insurer; or

(B) a person engaged in the business of insurance.

(iii) A public representative shall serve a term of three years.

(c) When a vacancy occurs in the membership of the board of directors for any reason:

(i) if the vacancy is of a member insurer, a replacement may be elected for the unexpired term by a majority vote of the remaining board members, subject to the approval of the commissioner; and

(ii) if the vacancy is of a public representative, the commissioner shall appoint a replacement for the unexpired term.

(d) In approving a selection or in appointing a member to the board of directors, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(e) Notwithstanding Subsections (1)(a) and (b), the commissioner shall, at the time of election, reelection, appointment, or reappointment adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board of directors is selected during any two-year period.

(2)

(a) A member of the board of directors may be reimbursed from the assets of the association for expenses incurred by the member as a member of the board of directors.

(b) A public representative appointed under Subsection (1)(a)(ii) may not receive compensation or benefits for the public representative's service, but in addition to reimbursement under Subsection (2)(a), a public representative may receive per diem and travel expenses established by the board with the approval of the commissioner.

(c) Except as provided in Subsections (2)(a) and (b), a member of the board of directors may not be compensated by the association for the member's services.

Amended by Chapter 391, 2018 General Session

31A-28-108 Powers and duties of the association.

(1)

(a) If a member insurer is an impaired insurer, subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, the association may provide the protections provided by this part.

(b) If the association makes the election described in Subsection (1)(a), the association may proceed under one or more of the options described in Subsection (3).

(2) If a member insurer is an insolvent insurer, the association shall provide the protections provided by this part by electing in its discretion to proceed under one or more of the options in Subsection (3).

(3) With respect to the covered portions of covered policies of an insolvent insurer, the association may:

(a)

(i)

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

(B) assure payment of the contractual obligations of the insolvent insurer; and

(ii) provide the money, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge such duties; or

(b) provide benefits and coverages in accordance with Subsection (4).

(4)

(a) The association may proceed under Subsection (3)(b) by:

(i) ensuring payment of benefits that would have been payable under the policies or contracts of the insurer, for claims incurred:

(A) with respect to group policies or contracts:

(I) not later than the earlier of the next renewal date under the policies or contracts or 45 days after the coverage date; and

(II) in no event less than 30 days after the coverage date; or

(B) with respect to nongroup policies or contracts:

(I) not later than the earlier of the next renewal date, if any, under the policies or contracts or one year from the coverage date; and

(II) in no event less than 30 days from the coverage date;

(ii) making diligent efforts to notify the following 30 days before any termination of the benefits that are provided under a policy or contract of the insurer:

(A) the known insureds, enrollees, or annuitants for nongroup policies and contracts;

(B) owners if other than an insured, enrollee, or annuitant; or

(C) group policy or contract owners for group policies and contracts; and

(iii) with respect to nongroup policies and contracts, making available substitute coverage on an individual basis, in accordance with Subsection (4)(b), to each known insured, enrollee, annuitant, or owner and to each individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage on an individual basis in accordance with Subsection (4)(b), if the insured, enrollee, or annuitant had a right under law or the terminated policy, contract, or annuity to:

(A) convert coverage to individual coverage; or

(B) continue an individual policy or contract in force until a specified age or for a specified time during which the insurer had:

(I) no right unilaterally to make changes in any provision of the policy or contract; or

(II) a right only to make changes in premium by class of risk.

(b)

(i) In providing the substitute coverage required under Subsection (4)(a)(iii), the association may offer to:

(A) reissue the terminated coverage; or

(B) issue an alternative policy or contract at actuarially justified rates.

(ii) An alternative or reissued policy or contract under Subsection (4)(b)(i):
(A) shall be offered without requiring evidence of insurability; and
(B) 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 an alternative or reissued policy or contract.
(c)
(i) An alternative policy or contract adopted by the association is subject to the approval of the commissioner.
(ii) The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.
(iii) An alternative policy or contract:
(A) shall contain at least the minimum statutory provisions required in this state; and
(B) provide benefits that are not unreasonable in relation to the premium charged.
(iv) The association shall set the premium for an alternative policy or contract in accordance with a table of rates that the association adopts.
(v) The premium described in Subsection (4)(c)(iv) shall reflect:
(A) the amount of insurance or coverage to be provided; and
(B) the age and class of risk of each insured.
(vi) For an alternative policy or contract issued under an individual policy or contract of the impaired or insolvent insurer:
(A) age shall be determined in accordance with the original policy or contract provisions; and
(B) class of risk is the class of risk under the original policy or contract.
(vii) For an alternative policy or contract issued to individuals insured or covered under a group policy or contract:
(A) age and class of risk shall be determined by the association in accordance with the alternative policy or contract provisions and risk classification standards approved by the commissioner; and
(B) the premium may not reflect any changes in the health of the insured after the original policy or contract was last underwritten.
(viii) An 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.
(d) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the association shall set the premium in a manner that is actuarially justified and in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to the prior approval of the commissioner or by a court of competent jurisdiction.
(e) 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 ceases on the date the coverage, policy, or contract is replaced by another similar coverage, policy, or contract by:
(i) the enrollee;
(ii) the owner;
(iii) the insured; or
(iv) the association.
(f)
(i) With respect to a claim unpaid as of the coverage date and an accident and health claim incurred during the period defined in Subsection (4)(a)(i), a provider of health care services,

by accepting a payment from the association upon a claim of the provider against an insured or enrollee whose insurer is an insolvent insurer, agrees to forgive the insured or enrollee of 20% of the debt that otherwise would be paid by the insolvent insurer had the insurer not been insolvent.

(ii) The obligations of a solvent insurer to pay all or part of the covered claim are not diminished by the forgiveness provided for in this section.

(5) When proceeding under Subsection (3)(b) 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 Subsection 31A-28-103(7)(c).

(6) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy, contract, or coverage under this part 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 part.

(7)

(a) Premium due after the coverage date with respect to the covered portion of a policy or contract of an impaired or insolvent insurer belongs to and is payable at the direction of the association. If a liquidator of an insolvent insurer requests the report, the association shall report to the liquidator the premium collected by the association.

(b) The association is liable to a policy or contract owner for unearned premiums due to the policy or contract owner arising after the coverage date with respect to the covered portion of the policy or contract.

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

(9) In carrying out its duties under Subsection (2), and subject to approval by a court in this state, the association may:

(a) impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that:

(i) the amounts that can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part; or

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

(b) 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; and

(c) if the receivership court imposes a temporary moratorium or moratorium charge 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, 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:

(i) established by the receiver; and

(ii) approved by the receivership court.

(10)

(a) A special deposit in this state held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, that is not turned over to the domiciliary receiver upon the entry of a final order of liquidation or order approving a

rehabilitation plan of a member insurer domiciled in any state shall be promptly paid to the association.

(b) Any amount paid under Subsection (10)(a) to the association less the amount retained by the association shall be treated as a distribution of estate assets pursuant to Sections 31A-27a-601, 31A-27a-602, and 31A-27a-701.

(11) If the association fails to act within a reasonable period of time as provided in this section, the commissioner has the powers and duties of the association under this part with respect to an impaired or insolvent insurer.

(12) The association may assist or advise the commissioner, upon the commissioner's request, concerning:

(a) rehabilitation;

(b) payment of claims;

(c) continuance of coverage; or

(d) the performance of other contractual obligations of any impaired or insolvent insurer.

(13)

(a) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over:

(i) an impaired or insolvent insurer concerning which the association is or may become obligated under this part; or

(ii) any person or property against which the association may have rights through subrogation or otherwise.

(b) The standing referred to in Subsection (13)(a) extends to all matters germane to the powers and duties of the association, including:

(i) proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer; and

(ii) the determination of the policies or contracts and contractual obligations.

(c) The association has the right to appear or intervene before a court in another state with jurisdiction over:

(i) an impaired or insolvent insurer for which the association is or may become obligated; or

(ii) any person or property against which the association may have rights through subrogation of the insurer's policy owners or contract owners.

(14)

(a) A person receiving benefits under this part is considered 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 part, whether the benefits are payments of, or on account of:

(i) contractual obligations;

(ii) continuation of coverage; or

(iii) provision of substitute or alternative policies, contracts, or coverages.

(b) As a condition precedent to the receipt of any right or benefits conferred by this part upon that person, the association may require an assignment to it of the rights and causes of action described in Subsection (14)(a) by any:

(i) payee;

(ii) policy or contract owner;

(iii) beneficiary;

(iv) insured;

(v) enrollee; or

(vi) annuitant.

(c) The subrogation rights obtained by the association under this Subsection (14) 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 part.

(d) In addition to Subsections (14)(a) through (c), the association has the common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contract, including in the case of a structured settlement annuity any rights of the owner, beneficiary, or payee of the annuity to the extent of benefits received pursuant to this part against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment of the annuity.

(e) If a provision of this Subsection (14) is invalid or ineffective with respect to a 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 portion of the policies, covered by the association.

(f) If the association has provided benefits with respect to a covered policy or contract and a person recovers amounts as to which the association has rights as described in this Subsection (14), the person shall pay to the association the portion of the recovery attributable to the covered policy or contract.

(15)

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

(i) enter into a contract that is necessary or proper to carry out the provisions and purposes of this part;

(ii) sue or be sued, including taking any legal actions necessary or proper to:

(A) recover any unpaid assessments under Section 31A-28-109; and

(B) settle claims or potential claims against the association;

(iii) borrow money to effect the purposes of this part;

(iv) employ or retain the persons necessary or the appropriate staff members to:

(A) handle the financial transactions of the association; and

(B) perform other functions as become necessary or proper under this part;

(v) take necessary or appropriate legal action to avoid or recover payment of improper claims;

(vi) exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic insurer providing life insurance or accident and health insurance, but in no case may the association issue policies or contracts other than those issued to perform the association's obligation under this part;

(vii) request information from a person seeking coverage from the association to aid the association in determining the association's obligations under this part with respect to the person;

(viii) 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 part;

(ix) take other necessary or appropriate action to discharge the association's duties and obligations under this part or to exercise the association's powers under this part; and

(x) act as a special deputy receiver if appointed by the commissioner.

(b) Any note or other evidence of indebtedness of the association under Subsection (15)(a)(iii) that is not in default:

(i) is a legal investment for a domestic member insurer; and

(ii) may be carried as admitted assets.

(c) A person seeking coverage from the association shall promptly comply with a request for information by the association under Subsection (15)(a)(vii).

(16) 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.

(17)

(a) At any time within 180 days after the coverage date, the association may elect to succeed to the rights and obligations of the member insurer that:

(i) accrue on or after the coverage date; and

(ii) relate to covered policies or contracts under any one or more indemnity reinsurance agreements:

(A) entered into by the member insurer as a ceding insurer and its reinsurer; and

(B) selected by the association.

(b) An election made pursuant to Subsection (17)(a) is effective as of the date of the order of liquidation.

(c) The association may make an election described in Subsection (17)(a) by notifying an affected reinsurer in writing, with verification of receipt, through:

(i) the association; or

(ii) a nationally recognized association representing state guaranty associations that is approved by the commissioner, that provides notice on behalf of the association.

(d) The association shall provide a copy of the notice described in Subsection (17)(c) to the receiver.

(e)

(i) The receiver of an insolvent insurer and each reinsurer of the ceding member insurers shall make available as soon as possible after commencement of formal delinquency proceedings the information described in Subsection (17)(e)(ii) to:

(A) the association; or

(B) a nationally recognized association representing state guaranty associations that is approved by the commissioner, on behalf of the association.

(ii) This Subsection (17)(e) applies to:

(A) copies of in-force contracts of reinsurance and the related records relevant to the determination of whether the in-force contracts of reinsurance should be assumed;

(B) notices of any default under a reinsurance contract; or

(C) any known event or condition that with the passage of time could become a default under a reinsurance contract.

(f) If the association makes an election under Subsection (17)(a), the association shall comply with Subsections (17)(f)(i) through (vii) with respect to the agreements selected by the association.

(i) For a policy or contract covered, in whole or in part, by the association, the association is responsible for:

(A) the unpaid premiums due under the agreements for periods both before and after the coverage date; and

(B) the performance of the other obligations to be performed after the coverage date.

(ii) The association may charge a policy or contract covered in part by the association the costs for reinsurance in excess of the obligations of the association, through reasonable allocation methods.

(iii) The association shall provide notice and an accounting to the receiver of a charge made pursuant to Subsection (17)(f)(ii).

(iv) The association is entitled to any amounts payable by the reinsurer under the agreements with respect to a loss or event that:
(A) occurs after the coverage date; and
(B) relates to a policy or a contract covered by the association, in whole or in part.
(v) On receipt of any amounts under Subsection (17)(f)(iv), the association shall pay to the beneficiary under the policy or contract on account of which the amounts were paid an 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 benefits paid or payable by the association on account of the policy or contract less the retention of the insurer applicable to the loss or event.
(vi)
(A) Within 30 days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to the items paid by either the member insurer, its receiver, or the indemnity reinsurer before the date of the association's election.
(B) Within five days of the completion of the calculation under Subsection (17)(f)(vi)(A):
(I) the reinsurer shall pay the receiver the amounts due for a loss or event before the coverage date, subject to any set-off for premiums unpaid for a period before the coverage date; and
(II) the association or the reinsurer shall pay any remaining balance due the other.
(C) A dispute over an amount due to either party shall be resolved:
(I) by arbitration pursuant to the terms of the affected reinsurance contract; or
(II) if the reinsurance contract contains no arbitration clause, as otherwise provided by law.
(D) If the receiver receives an amount due the association pursuant to Subsection (17)(f)(iv), the receiver shall remit that amount to the association as promptly as practicable.
(vii) If the association, or the receiver on behalf of the association, within 60 days of the election, pays the premiums due for periods both before and after the coverage date that relate to policies or contracts covered by the association, in whole or in part, the reinsurer may not:
(A) terminate the reinsurance agreement for failure to pay premium, to the extent the reinsurance agreement relates to a policy or contract covered by the association, in whole or in part; and
(B) set off against amounts due the association an amount due:
(I) under another policy or contract; or
(II) as an unpaid amount due from a person other than the association.

(g)
(i) This Subsection (17)(g) applies during the period that:
(A) begins on the coverage date; and
(B) ends:
(I) on the election date; or
(II) if no election date occurs, 180 days after the coverage date.
(ii) During the period described in Subsection (17)(g)(i):
(A) neither the association nor the reinsurer have a right or obligation under a reinsurance contract that the association may assume under Subsection (17)(a), whether for a period before or after the coverage date; and

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

(iii) Notwithstanding Subsection (17)(g)(ii), once the association elects to assume a reinsurance contract, the parties' rights and obligations are governed by Subsections (17)(f)(i) through (vi).

(h) If the association does not elect to assume a reinsurance contract by the election date pursuant to Subsection (17)(a), the association has no right or obligation with respect to the reinsurance contract, whether for a period before or after the coverage date.

(i) An insurer other than the association succeeds to the rights and obligations of the association under Subsections (17)(a) through (f) effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in Subsections (17)(a) through (f) provided that:

(i) the association transfers its obligations to the other insurer;

(ii) the association and the other insurer agree to the transfer;

(iii) the indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

(iv) the obligations described in Subsection (17)(f)(v) may not apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer;

(v) the transferring party shall give notice in writing, with verification of receipt, to the affected reinsurer not less than 30 days before the effective date of the transfer; and

(vi) this Subsection (17)(i) may not apply if the association has previously expressly determined in writing that the association will not exercise the election referred to in Subsections (17)(a) through (f).

(j)

(i) This Subsection (17) supersedes the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the coverage date, to:

(A) the receiver of an insolvent member insurer; or

(B) another person.

(ii) The receiver is entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to a loss or event that occurs before the coverage date, subject to applicable setoff provisions.

(k) Except as otherwise expressly provided in Subsections (17)(a) through (j), this Subsection (17) does not:

(i) alter or modify the terms and conditions of a reinsurance agreement of the insolvent member insurer;

(ii) abrogate or limit a right any reinsurer to claim that it is entitled to rescind a reinsurance agreement;

(iii) give a policy owner, policy holder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance agreement;

(iv) limit or affect the association's rights as a creditor of the estate of an insolvent insurer against the assets of the estate; or

(v) apply to a reinsurance agreement that covers property or casualty risks.

(18) 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 part in an economical and efficient manner.

(19) If the association arranges or offers to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(20)

(a) Venue in a suit against the association arising under this part is Salt Lake County.

(b) The association may not be required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

Amended by Chapter 391, 2018 General Session

31A-28-109 Assessments.

(1)

(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 class or subclass, at the time and for the amounts that the board of directors finds necessary.

(b) Member insurer liability for an assessment is established beginning on the coverage date, regardless of when the assessment is called.

(c) A called assessment:

(i) is due not less than 30 days after prior written notice to the member insurer; and

(ii) shall accrue interest at 10% per annum on and after the due date.

(d) Notwithstanding Subsection (1)(c), the association may:

(i) assess the association's members as of the coverage date; and

(ii) defer the collection of the assessment described in Subsection (1)(d)(i).

(e) An assessment:

(i) has the force and effect of a judgment lien against the member insurer; and

(ii) may not be extinguished until paid.

(2) There are two classes of assessments:

(a) a Class A assessment:

(i) shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses; and

(ii) may be authorized and called regardless of whether the assessment is related to a particular impaired or insolvent insurer; and

(b) a Class B assessment shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Section 31A-28-108 with regard to an impaired or an insolvent insurer.

(3)

(a)

(i) The amount of a Class A assessment:

(A) shall be determined by the board of directors; and

(B) may be authorized and called on a pro rata or non-pro rata basis.

(ii) If the Class A assessment is pro rata, the board of directors may credit the assessment against future Class B assessments.

(b)

(i) Except as provided in Subsection (3)(c)(i), the amount of a Class B assessment shall be allocated for assessment purposes:

(A) between the life insurance and annuity class and the accident and health insurance class; and

(B) among the subclasses of the life insurance and annuity class.

(ii) An allocation of a Class B assessment under Subsection (3)(b)(i) shall be made pursuant to an allocation formula that may be based on:

(A) the premiums or reserves of the impaired or insolvent insurer; or

(B) any other standard determined by the board of directors in the board of directors' sole discretion as being fair and reasonable under the circumstances.

(c)

(i) For a Class B assessment for the long-term care insurance written by an impaired or insolvent insurer, the association:

(A) shall, except as prohibited in Subsection (3)(c)(i)(B), allocate the amount of the Class B assessment according to a methodology that provides for 25% of the assessment to be allocated to accident and health member insurers and 75% of the assessment to be allocated to life insurance and annuity member insurers;

(B) may not impose liability on a member insurer that is a health maintenance organization for an assessment with a coverage date before January 1, 2021;

(C) may not consider the premiums from a health maintenance organization contract when calculating the share of an assessment with a coverage date before January 1, 2021, allocated to accident and health member insurers; and

(D) shall include the methodology described in Subsection (3)(c)(i)(A) in the plan of operation established and approved under Section 31A-28-110.

(ii) A Class B assessment against a member insurer for the life insurance subclass, the annuity subclass, and the unallocated annuity subclass shall be in the proportion that the premiums received on business in the state by the member insurer on policies or contracts included in the class or subclass for the three most recent calendar years for which information is available preceding the year which includes the coverage date bears to the premiums received on business in the state during the same three-calendar-year period by all assessed member insurers on policies or contracts included in the class or subclass.

(iii) A Class B assessment against a member insurer for an accident and health insurance class shall be in the proportion that the premiums received on business in the state by each assessed member insurer on policies or contracts included in the class for the most recent calendar year for which information is available preceding the year in which the assessment is made bears to the premiums received on business in this state on policies or contracts included in the class for that calendar year by all assessed member insurers.

(d) 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 part.

(e) Classification and computation of assessments and premiums under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(f) The association shall notify each member insurer of the member insurer's anticipated pro rata share of an authorized assessment not yet called within 180 days after the day on which the assessment is authorized.

(4)

(a) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations.

(b) If an assessment against a member insurer is abated or deferred in whole or in part under Subsection (4)(a), 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.

(c) Once a condition that caused a deferral is removed or rectified, the member insurer shall pay the assessments that were deferred pursuant to a repayment plan approved by the association.

(5)

(a)

(i) Subject to Subsection (5)(b), the total of the assessments authorized by the association on a member insurer for each class or subclass may not in any one calendar year exceed 2% of the member insurer's average annual assessable premium in that class or subclass as defined in Subsection (3).

(ii) If two or more assessments are authorized in one calendar year with respect to two or more member insurers that become impaired or insolvent in different calendar years, the average annual assessable premiums for purposes of the aggregate assessment percentage limitation calculated for each subclass or class under Subsection (5)(a)(i) shall be equal and limited to the highest of the total average annual assessable premium averages for the different calendar year periods involved in the assessment or assessments.

(iii) If the maximum assessment together with the other assets of the association do not provide in one year an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon after as permitted by this part.

(b) The board of directors 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.

(c) If the maximum assessment for the life insurance subclass or the annuity subclass in any one year does not provide an amount sufficient to carry out the responsibilities of the association, the board of directors shall assess the other of the subclasses of the life insurance and annuity class for the necessary additional amount:

(i) pursuant to Subsection (3)(b); and

(ii) subject to the maximum stated in Subsection (5)(a).

(6)

(a) The board of directors may, by an equitable method established in the plan of operation, refund to member insurers in proportion to the contribution of each member insurer to that subclass the amount by which the assets of the subclass exceed the amount the board of directors finds is necessary to carry out the obligations of the association with regard to that subclass, including assets accruing from:

(i) assignment;

(ii) subrogation;

(iii) net realized gains; and

(iv) income from investments.

(b) Notwithstanding Subsection (6)(a), a reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.

(7) A member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this part, may consider the amount reasonably necessary to meet its assessment obligations under this part.

(8)

(a) The association shall issue to each member insurer paying an assessment under this part, other than a Class A assessment, a certificate of contribution, in a form approved by the commissioner, for the amount of the assessment paid.

(b) The outstanding certificates described in Subsection (8)(a) shall be of equal dignity and priority without reference to amounts or dates of issue.

(c)

(i) A certificate of contribution described in Subsection (8)(a) may be shown by the member insurer in its financial statement as an asset in the amount of the certificate of contribution less the amount by which the insurer's premium taxes have already been reduced with respect to the certificate.

(ii) For good cause shown, the commissioner may order the insurer to show a different amount in its financial statement than the amount under Subsection (8)(c)(i).

(9)

(a)

(i) A member insurer that wishes to protest all or part of an assessment shall pay, when due, the full amount of the assessment as specified in the notice provided by the association.

(ii) The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal.

(iii) The payment shall be accompanied by a statement in writing:

(A) that the payment is made under protest; and

(B) giving a brief description of the grounds for the protest.

(b)

(i) The association shall notify the member insurer, in writing, of the association's determination with respect to the protest within 60 days after the day on which the payment of an assessment is made under protest by a member insurer, unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(ii) The association shall notify the protesting member insurer in writing of the final decision within 30 days after the day on which a final decision is made by the association.

(iii) The protesting member insurer may appeal the final action of the association to the commissioner within 60 days after the day on which the protesting member insurer receives a notice of the final decision from the association.

(c) The association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(d)

(i) If a protest or appeal on an assessment concludes that an amount was paid in error or excess by a member insurer, the association shall return the amount paid in error or excess to the member insurer.

(ii) The association shall pay interest on a refund due to a protesting member insurer at the rate actually earned by the association.

(10)

(a) The association may request information from a member insurer to aid in the exercise of the association's power under this part.

(b) A member insurer shall comply promptly with a request of the association under this Subsection (10).

Amended by Chapter 391, 2018 General Session

31A-28-110 Plan of operation.

(1)

(a) The association shall submit to the commissioner a plan of operation and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association.
(b) The plan of operation and any amendments become effective:
(i) upon the commissioner's written approval; or
(ii) after 30 days from the date the plan of operation or amendment is submitted to the commissioner if the commissioner has not disapproved the plan or amendment.
(c)
(i) If the association fails to submit a suitable amendment to the plan, the commissioner, after notice and hearing, shall adopt reasonable rules that are necessary or advisable to effectuate the provisions of this part.
(ii) The rules described in Subsection (1)(c)(i) continue in force until:
(A) modified by the commissioner; or
(B) superseded by an amendment to the plan:
(I) submitted by the association; and
(II) approved by the commissioner.
(2) A member insurer shall comply with the plan of operation.
(3) The plan of operation shall, in addition to any other requirement in this part:
(a) establish procedures for handling the assets of the association;
(b) establish the amount and method of reimbursing members of the board of directors under Section 31A-28-107;
(c) establish regular places and times for meetings of the board of directors, including telephone conference calls;
(d) establish procedures for records to be kept of the financial transactions of:
(i) the association;
(ii) the association's agents; and
(iii) the board of directors;
(e) subject to Section 31A-28-107, establish the procedures to be followed for:
(i) selecting members to the board of directors; and
(ii) submitting the selected members to the commissioner for approval;
(f) establish any additional procedures for assessments under Section 31A-28-109;
(g) establish procedures under which a member insurer may be removed from the board of directors for cause, including when the member insurer becomes an impaired or insolvent insurer;
(h) require the board of directors to establish policies and procedures that address conflicts of interests; and
(i) contain additional provisions necessary or proper for the execution of the powers and duties of the association.
(4)
(a) The plan of operation may provide that any or all powers and duties of the association, except those under Subsection 31A-28-108(14)(d) and Section 31A-28-109, are delegated to a corporation, association, or other organization that will perform functions similar to those of the association, or its equivalent, in two or more states.
(b) A corporation, association, or organization described in Subsection (4)(a) shall be:
(i) reimbursed for any payments made on behalf of the association; and
(ii) paid for its performance of any function of the association.
(c) A delegation under this Subsection (4):
(i) takes effect only with the approval of:

(A) the board of directors; and
(B) the commissioner; and
(ii) may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this part.

Amended by Chapter 292, 2010 General Session

31A-28-111 Duties and powers under this part.

The duties and powers described in this section are in addition to the duties and powers enumerated elsewhere in this part.

(1) The commissioner shall:
(a) upon request of the board of directors, provide the association with a statement of the premiums for each member insurer:
(i) in this state; and
(ii) any other appropriate state; and
(b) if 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.

(2) Notice to the impaired insurer under Subsection (1)(b) constitutes notice to the shareholders of the impaired insurer if the impaired insurer has shareholders.

(3) The failure of the impaired insurer to promptly comply with the commissioner's demand under Subsection (1)(b) does not excuse the association from the performance of its powers and duties under this part.

(4)
(a) After notice and hearing, the commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer not domiciled in this state that fails to:
(i) pay an assessment when due; or
(ii) comply with the plan of operation.
(b)
(i) As an alternative to suspending or revoking a certificate of authority under Subsection (4)(a), the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due.
(ii) A forfeiture described in Subsection (4)(b)(i):
(A) may not exceed 5% of the unpaid assessment per month; and
(B) may not be less than $100 per month.

(5)
(a) A final action of the board of directors or the association may be appealed to the commissioner by any member insurer if appeal is taken within 60 days of the date the member insurer received notice of the final action being appealed.
(b) If a member insurer is appealing an assessment, the amount assessed shall be:
(i) paid to the association; and
(ii) made available to meet association obligations during the pendency of an appeal.
(c) If the appeal on the assessment described in Subsection (5)(b) is upheld, the amount paid in error or excess shall be returned to the member insurer.
(d) Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(6) The receiver of an impaired insurer shall notify the interested persons of the effect of this part.

Amended by Chapter 391, 2018 General Session

31A-28-112 Reports.

(1) The commissioner shall:
  (a) report to the board of directors when:
    (i) the commissioner takes an action set forth in Section 31A-27a-201;
    (ii) an event described in Section 31A-17-603, 31A-17-604, or 31A-17-605 occurs; or
    (iii) the commissioner receives a report from any other commissioner indicating that an action described in Subsection (1)(a)(i) has been taken in another state;
  (b) include in the report to the board of directors required by Subsection (1)(a):
    (i) the significant details of the action taken;
    (ii) the significant details of an event described in Subsection (1)(a)(ii); or
    (iii) the report received from another commissioner;
  (c) promptly report to the board of directors when the commissioner has reasonable cause to believe from an examination of any member insurer, whether completed or in process, that the member insurer may be an impaired or insolvent insurer; and
  (d) furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners.

(2)
  (a) The board of directors may use the information contained in the ratios and listings described in Subsection (1)(d) in carrying out the board of directors' duties and responsibilities under this part.
  (b) The board of directors shall keep the report and the information contained in the ratios and listings confidential until the commissioner or other lawful authority publishes the information.

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

(4)
  (a) The board of directors may make reports and recommendations to the commissioner upon any matter germane to:
    (i) the solvency, liquidation, rehabilitation, or conservation of any member insurer; or
    (ii) the solvency of any insurer seeking to do business in this state.
  (b) The reports and recommendations of the board of directors described in Subsection (4)(a) are not public documents.

(5) The board of directors may, upon majority vote, notify the commissioner of any information indicating that a member insurer may be an impaired or insolvent insurer.

(6) The board of directors may make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

(7)
  (a) At the conclusion of any member insurer insolvency in which the association was obligated to pay covered claims, the board of directors shall prepare a report to the commissioner containing the information the board of directors has in its possession bearing on the history and causes of the insolvency.
  (b) In preparing a report on the history and causes of insolvency of a particular member insurer, the board of directors may cooperate with:
    (i) the board of directors of a guaranty association in another state; or

(ii) an organization described in Subsection 31A-28-108(16).
(c) The board of directors may adopt by reference any report prepared by:
(i) a guaranty association in another state; or
(ii) an organization described in Subsection 31A-28-108(16).

Amended by Chapter 391, 2018 General Session

31A-28-113 Credit for assessments paid.

(1)
(a) A member insurer may offset against its premium tax, income tax, or franchise tax liability to this state an assessment described in Subsection 31A-28-109(2)(b) to the extent of 20% of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid.
(b) To the extent that the offsets described in Subsection (1)(a) exceed premium tax liability, the offsets may be carried forward and used to offset premium tax liability in future years.
(c) If a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(2)
(a) A member insurer that is exempt from taxes described in Subsection (1) may recoup the member insurer's assessment by a surcharge on premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the commissioner.
(b) Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, income tax, franchise tax, producer commission, or, to the extent allowed under federal law, medical loss ratio.
(c) 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.

(3)
(a) Money shall be paid by the member insurers to the state in a manner required by the State Tax Commission if the money:
(i) is acquired by refund in accordance with Subsection 31A-28-109(6) from the association by member insurers; and
(ii) has been offset against premium taxes as provided in Subsection (1).
(b) The association shall notify the commissioner that the refunds described in Subsection (3)(a) have been made.

Amended by Chapter 391, 2018 General Session

31A-28-114 Miscellaneous provisions.

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

(2)
(a) The board of directors shall keep a record of a meeting of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 31A-28-108.
(b) A record of the association with respect to an impaired or insolvent insurer may not be disclosed before the earlier of:
(i) the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer;

(ii) the termination of the impairment or insolvency of the insurer; or
(iii) upon the order of a court of competent jurisdiction.
(c) Nothing in this Subsection (2) limits the duty of the association to render a report of its activities under Section 31A-28-115.
(3)
(a) For the purpose of carrying out its obligations under this part, the association is considered to be a creditor of an 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 Subsection 31A-28-108(14).
(b) Assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue the covered policies and pay the contractual obligations of the impaired or insolvent insurer as required by this part.
(c) As used in this Subsection (3), assets attributable to covered policies or contracts are that proportion of the assets which the reserves that should have been established for covered policies or contracts bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.
(4)
(a) As a creditor of the impaired or insolvent insurer under Subsection (3) and consistent with Section 31A-27a-701, the association and any other similar association 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 and any other similar association.
(b) If, within 180 days of a final determination of insolvency of a member insurer by the receivership court, the receiver has not made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to the 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 proposal for disbursement of these assets.
(5)
(a) Before the termination of a liquidation, rehabilitation, or conservation proceeding, when making an equitable distribution of the ownership rights of the insolvent insurer, the court may take into consideration the contributions of the respective parties, including:
(i) the association;
(ii) the shareholders;
(iii) policy owners, contract owners, certificate holders, and enrollees of the insolvent insurer; and
(iv) any other party with a bona fide interest in making an equitable distribution of the ownership rights of the insolvent insurer.
(b) In making a determination under Subsection (5)(a), the court shall consider the welfare of the policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.
(c) A distribution to any stockholder of an impaired or insolvent insurer may not be made until and unless the total amount of valid claims of the association with interest has been fully recovered by the association for funds expended in carrying out its powers and duties under Section 31A-28-108 with respect to the member insurer.

Amended by Chapter 391, 2018 General Session

31A-28-115 Examination of the association -- Annual report.
(1) The association shall be subject to examination and regulation by the commissioner.

(2) The board of directors shall submit to the commissioner each year, not later than 120 days after the association's fiscal year:
(a) a financial report in a form approved by the commissioner; and
(b) a report of its activities during the preceding fiscal year.
(3) At the request of a member insurer, the association shall provide the member insurer with a copy of a report submitted under Subsection (2).

Amended by Chapter 161, 2001 General Session

31A-28-116 Tax exemptions.

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

Repealed and Re-enacted by Chapter 211, 1991 General Session

31A-28-117 Immunity.

(1) For any action or omission committed in the performance of their powers and duties under this part, there is no liability on the part of, and no cause of action of any nature shall arise against:
(a) any member insurer;
(b) a member insurer's agents or employees;
(c) the association;
(d) the association's:
(i) agents or employees; or
(ii) members of the board of directors;
(e) representatives of persons described in Subsections (1)(a) through (d);
(f) the commissioner; or
(g) the commissioner's representatives.
(2) The immunity described in Subsection (1) extends to:
(a) the participation in any organization of one or more other state associations of similar purposes;
(b) an organization described in Subsection (2)(a); and
(c) the agents or employees of an organization described in Subsection (2)(a).

Amended by Chapter 161, 2001 General Session

31A-28-118 Stay of proceedings -- Reopening default judgments.

(1) A proceeding in which the insolvent insurer is a party in any court in this state shall be stayed 180 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties.
(2) The association may apply to have a judgment under any decision, order, verdict, or finding based on default set aside by the same court that made the judgment. The association shall be permitted to defend against the suit on the merits.

Amended by Chapter 292, 2010 General Session

31A-28-119 Prohibited advertisement of the association -- Notice to owners of policies and contracts.

(1)

(a) Except as provided in Subsection (1)(b), a person, including a member insurer, producer, or affiliate of a member insurer may not make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over a radio station or television station, or in any other way, any advertisement, announcement, or statement written or oral, that uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or coverage for which the guaranty association provides coverage under this part.

(b) This section does not apply to:

(i) the association; or

(ii) another entity that does not sell or solicit insurance.

(2)

(a) The association shall:

(i) have a summary document describing the general purposes and current limitations of this part that complies with Subsection (3); and

(ii) submit the summary document described in Subsection (2)(a)(i) to the commissioner for approval.

(b) A member insurer may not deliver a policy or contract to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is also delivered to the policy owner, contract owner, certificate holder, or enrollee before, or at the time of, delivery of the policy or contract.

(c) The summary document shall be available upon request by a policy owner, contract owner, certificate holder, or enrollee.

(d) The distribution, delivery, or contents or interpretation of the summary document does not guarantee that:

(i) the policy or the contract is covered in the event of the impairment or insolvency of a member insurer; or

(ii) the policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer.

(e) The summary document shall be revised by the association as amendments to this part may require.

(f) Failure to receive the summary document as required in Subsection (2)(b) does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this part.

(3)

(a) The summary document described in Subsection (2) shall contain a clear and conspicuous disclaimer on its face.

(b) The commissioner shall, by rule, establish the form and content of the disclaimer described in Subsection (3)(a), except that the disclaimer shall:

(i) state the name and address of:

(A) the association; and

(B) the department;

(ii) prominently warn a policy owner, contract owner, certificate holder, or enrollee that:

(A) the association may not cover the policy or contract; or

(B) if coverage is available, it is:

(I) subject to substantial limitations and exclusions; and

(II) conditioned on continued residence in the state;

(iii) state the types of policies or contracts for which the association will provide coverage;
(iv) state that the member insurer and the member insurer's producers 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;
(v) state that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the association when selecting an insurer;
(vi) explain the rights available and procedures for filing a complaint to allege a violation of this part; and
(vii) provide other information as directed by the commissioner including sources for information about the financial condition of insurers provided that the information:
(A) is not proprietary; and
(B) is subject to disclosure under public records laws.

(4)
(a) An insurer, or the insurer's producer, may not deliver a policy or contract described in Subsection 31A-28-103(6) and wholly excluded under Subsection 31A-28-103(7)(a) from coverage under this part unless the insurer or the insurer's producer, prior to or at the time of delivery, gives the policy owner, contract owner, certificate holder, or enrollee a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the association.
(b) The commissioner shall by rule specify the form and content of the notice required by Subsection (4)(a).

(5) A member insurer shall retain evidence of compliance with Subsection (2) for the later of:
(a) three years; or
(b) until the conclusion of the next market conduct examination by the department of insurance where the member insurer is domiciled.

Amended by Chapter 391, 2018 General Session

31A-28-120 Prospective application.

Notwithstanding any prior or subsequent law, the provisions of this part that are in effect on the date on which the association first becomes obligated for the policies or contracts of an insolvent or impaired insurer govern the association's rights and obligations to the policy owners, contract owners, certificate holders, and enrollees of the insolvent or impaired insurer.

Amended by Chapter 391, 2018 General Session