508C.9 Assessments.

1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account established pursuant to section 508C.6, at the time and for the amounts the board finds necessary. An assessment is due not less than thirty days after prior written notice has been sent to the member insurers and accrues interest at ten percent per annum commencing on the due date.

2. There are two classes of assessments as follows:

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

b. Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 508C.8 with regard to an impaired or an insolvent insurer.

3. *a.* The amount of a class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the assessment be credited against future class B assessments.

b. The amount of a class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or the reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

c. The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation pursuant to section 508C.10, and as approved by the commissioner. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

d. Class B assessments against member insurers for each account shall be in the proportion that the average of the aggregate premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available, preceding the year in which the member insurer became insolvent, or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired, bears to premiums received on business in this state for those calendar years by all assessed member insurers.

e. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection 2 and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

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

5. *a.* (1) Subject to the provisions of subparagraph (2) of this paragraph "*a*", the total of all assessments authorized by the association with respect to a member insurer for each of the accounts established pursuant to section 508C.6, and designated as the health account, the life

insurance account, the annuity account, and the unallocated annuity contract account, shall not in any one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the member insurer becomes impaired or insolvent.

(2) If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referred to in subparagraph (1) of this paragraph *"a"* shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated pursuant to this section.

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

b. The board may provide in its 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 either the life insurance account, the annuity account, or the unallocated annuity contract account in one year does not provide an amount sufficient to carry out the responsibilities of the association, the board, pursuant to subsection 3, paragraph *"b"*, shall access any of the other said accounts for the necessary additional amount, subject to the maximum assessments stated in paragraph *"a"* of this subsection.

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

7. In determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this chapter, it is proper for a member insurer to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

8. The association shall issue to each member insurer paying a class B assessment under this chapter, a certificate of contribution in a form prescribed by the commissioner for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in the form, for the amount, and for a period of time as the commissioner may approve.

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

b. Within sixty days following the payment of an assessment under protest by a member insurer, the association shall either notify the protesting member insurer in writing of its determination with respect to the protest or notify the protesting member insurer that additional time is required to resolve the issues raised by the protest.

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

d. As an alternative to rendering a final decision with respect to a protest of an assessment,

the association may refer the protest to the commissioner for a final decision, with or without a recommendation from the association.

e. If a protest or subsequent appeal of an assessment is upheld in favor of the protesting member insurer, the amount paid in error or the excess shall be refunded to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association during the pendency of the protest or any subsequent appeal.

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

87 Acts, ch 223, §9; 88 Acts, ch 1135, §10; 90 Acts, ch 1234, §23 – 25; 92 Acts, ch 1162, §9, 10; 2000 Acts, ch 1023, §14; 2011 Acts, ch 70, §13, 14; 2019 Acts, ch 12, §20 – 22, 35, 36

Referred to in §508C.3, 508C.8, 508C.10, 508C.19

2019 amendments apply beginning March 29, 2019; 2019 Acts, ch 12, §35, 36