CHAPTER 508C

IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Referred to in §87.4, 296.7, 331.301, 364.4, 505.28, 505.29, 507C.2, 508D.3, 514B.25A, 515I.4A, 669.14, 670.7

508C.1 Title.

This chapter shall be cited as the *"Iowa Life and Health Insurance Guaranty Association Act"*.

87 Acts, ch 223, §1

508C.2 Purpose.

1. The purpose of this chapter is to protect, subject to certain limitations, the persons specified in section 508C.3, subsection 1, against failure in the performance of contractual obligations under life, health, and annuity policies, plans, or contracts specified in section 508C.3, subsection 2, because of the impairment or insolvency of the member insurer which issued the policies, plans, or contracts.

2. To provide this protection, an association of member insurers is created to enable the guaranty of payments of benefits and continuation of coverages as limited by this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

87 Acts, ch 223, §2; 2019 Acts, ch 12, §2, 35, 36

Referred to in §508C.4

2019 amendment applies beginning March 29, 2019; 2019 Acts, ch 12, §35, 36

508C.3 Scope.

1. This chapter shall provide coverage under the policies and contracts specified in subsection 2 to all of the following:

a. Persons, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, who are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies, contracts, or certificates, of the persons covered under paragraph *"b"*.

b. Persons who are owners of or certificate holders or enrollees under the policies or contracts specified in subsection 2, other than unallocated annuity contracts and structured settlement annuities, or are enrollees, insureds, or annuitants under the policies or contracts, and who are either of the following:

(1) Residents of this state.

(2) Nonresidents of this state if all of the following conditions are met:

(a) The state in which the person resides has an association similar to the association created in this chapter.

(b) The person is not eligible for coverage by an association described in subparagraph division (a) in any other state due to the fact that the insurer or the health maintenance organization was not licensed in the state at the time specified in that state's guaranty association law.

(c) The member insurer that issued the policy or contract is domiciled in this state.

c. Persons who are the owners of unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state.

d. (1) A payee, or the beneficiary of a payee if the payee is deceased, of a structured settlement annuity, if the payee or beneficiary of the structured settlement annuity is either of the following:

(a) The payee or beneficiary of the structured settlement annuity is a resident of this state regardless of where the owner of the structured settlement annuity resides.

(b) The payee or beneficiary of the structured settlement annuity is not a resident of this state and either of the following conditions is met:

(i) The owner of the structured settlement annuity is a resident of this state.

(ii) The owner of the structured settlement annuity is not a resident of this state and both of the following are applicable:

(A) The insurer that issued the structured settlement annuity is domiciled in this state.

(B) The state in which the owner of the structured settlement annuity resides has an association similar to the association created by this chapter.

(2) Subparagraph (1), subparagraph division (b) shall not be applicable if either the payee or beneficiary of the payee if the payee is deceased, or the owner of the structured settlement annuity is eligible for coverage by the association of the state in which the payee, beneficiary, or owner resides.

e. A person who is a resident of this state and, only in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, that person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in a situation where a person could be provided coverage by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by the association of only one state.

2. This chapter shall provide coverage to the persons specified in subsection 1 under policies or contracts of direct life insurance, health insurance, or annuities, supplemental contracts, certificates under group policies or contracts, and unallocated annuity contracts issued by member insurers. For purposes of this chapter, health insurance shall include without limitation health maintenance organization subscriber contracts and certificates, long-term care insurance, and disability insurance policies.

3. Coverage under this chapter shall not be provided to any of the following:

a. A person who is a payee, or a beneficiary of a payee if the payee is deceased, of a contract owner who is a resident of this state, if the payee or the beneficiary of the payee is provided any coverage by the association of another state.

b. A person who is covered pursuant to subsection 1, paragraph "*c*", if that person is provided any coverage by the association of another state.

c. A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. §5891(c)(3)(A), regardless of when the transaction occurred.

4. This chapter does not apply to any of the following:

a. Except for a portion of a policy or contract, including a rider, that provides coverage for long-term care or any health insurance benefits, any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract and employed in calculating returns or changes in value, averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average for the same four-year period or over such lesser period if the policy or contract was issued less than four years before the association became obligated; and on or after the date on which the association becomes obligated with

respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available.

b. That portion or part of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract holder.

c. A policy or contract or part of a policy or contract assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.

d. An unallocated annuity contract issued to or in connection with an employee benefit plan protected under the federal pension benefit guaranty corporation, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan.

e. A portion of an unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons, or any portion of a financial guarantee.

f. A policy or contract issued by a company which is licensed under chapter 509A, 512A, 512B, 514, 518, 518A, or 520, or under section 514B.33.

g. Except for a policy issued pursuant to section 515.48, subsection 5, paragraph *"a"*, a policy or contract issued by a company which is licensed under chapter 515.

h. A charitable gift annuity under chapter 508F.

i. An annuity contract issued to a government lottery.

j. A funding agreement under section 508.31A.

k. An obligation that does not arise under the express written terms of a covered policy or contract issued by the member insurer to the enrollee, certificate holder, policy owner, or contract owner including without limitation all of the following:

(1) A claim based on marketing materials.

(2) A claim based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements.

(3) A claim based on misrepresentation of or misrepresentation regarding policy or contract benefits.

(4) An extra-contractual claim.

(5) A claim for penalties, consequential damages, or incidental damages.

l. A contractual agreement that establishes a member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

m. A portion of a covered policy to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the covered policy, but which have not been credited to the covered policy, or as to which the covered policy owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a covered policy's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under the covered policy, the interest or change in value determined by using the procedures defined in the covered policy will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and the crediting interest or changing value shall not be subject to forfeiture.

n. A policy or contract issued in this state by a member insurer at a time the insurer was not licensed or did not have a certificate of authority to issue the policy or contract in this state.

o. A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under any of the following:

(1) A multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002, paragraph 40.

(2) A minimum premium group insurance plan.
(3) A stop-loss group insurance plan.
(4) An administrative services-only contract.

p. A portion of a policy or contract to the extent that it provides for any of the following:
(1) Dividends or experience rating credits.
(2) Voting rights.
(3) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with service to or administration of the policy or contract.

q. A portion of a policy or contract to the extent that the assessments authorized by section 508C.9 with respect to the policy or contract are preempted by federal or state law.

r. A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to any of the following:
(1) 42 U.S.C. ch. 7, subch. XVIII, Part C or Part D, commonly known as Medicare Part C and D, or any regulations issued pursuant thereto.
(2) 42 U.S.C. ch. 7, subch. XIX, commonly known as Medicaid, or any regulations issued pursuant thereto.

s. Structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction as defined in 26 U.S.C. §5891(c)(3)(A).

5. *a.* The benefits that the association may become obligated to cover shall in no event exceed the lesser of either of the following:
(1) The contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an impaired or insolvent insurer.
(2) Any of the following:
(a) With respect to one life, regardless of the number of policies or contracts:
(i) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance.
(ii) Five hundred thousand dollars for health benefit plans; three hundred thousand dollars for health insurance benefits which are disability income protection coverage as defined by the commissioner by rule pursuant to section 514D.4; three hundred thousand dollars for long-term care insurance as defined in section 514G.103; or one hundred thousand dollars for other health insurance benefits including any net cash surrender and net cash withdrawal values.
(iii) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.
(iv) With respect to each payee of a structured settlement annuity, or the beneficiary or beneficiaries of the payee if the payee is deceased, two hundred fifty thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values.
(b) (i) With respect to each individual participating in a retirement benefit plan established under section 401, 403(b), or 457 of the United States Internal Revenue Code, or each unallocated annuity contract account, excluding a plan established under section 401, 403(b), or 457 of the United States Internal Revenue Code, not more than two hundred fifty thousand dollars in the aggregate, in present value annuity benefits, including net cash surrender and net cash withdrawal values for the beneficiaries of the deceased individual.
(ii) However, the association shall not in any event be obligated to cover more than an aggregate of three hundred fifty thousand dollars in benefits with respect to any one life under subparagraph division (a) and this subparagraph division (b), except with respect to benefits for health benefit plans under subparagraph division (a), subparagraph subdivision (ii), in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual, or more than five million dollars in benefits to one owner of multiple nongroup policies of life insurance regardless of whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, and regardless of the number of policies and contracts held by the owner.

(c) With respect to a plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts not included under subparagraph division (b), not more than five million dollars in benefits, regardless of the number of contracts held by the plan sponsor. However, where one or more such unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, the association shall provide coverage if the largest interest in the trust or entity owning the contract is held by a plan sponsor whose principal place of business is in the state but in no event shall the association be obligated to cover more than five million dollars in benefits in the aggregate with respect to all such unallocated contracts.

b. The limitations on the association's obligation to cover benefits that are set forth under this subsection do not take into account the association's subrogation and assignment rights or the extent to which such benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The cost of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to the association's subrogation and assignment rights.

c. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

6. In performing its obligations to provide coverage under this chapter, the association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of an insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

87 Acts, ch 223, §3; 88 Acts, ch 1135, §1 – 3; 89 Acts, ch 83, §67; 92 Acts, ch 1162, §6, 7; 98 Acts, ch 1057, §6; 2000 Acts, ch 1023, §13; 2008 Acts, ch 1123, §14; 2010 Acts, ch 1063, §1 – 7; 2010 Acts, ch 1193, §60; 2014 Acts, ch 1092, §111 – 114; 2019 Acts, ch 12, §3 – 6, 35, 36; 2020 Acts, ch 1063, §274

Referred to in §508C.2, 508C.5, 508C.8

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

508C.4 Construction.

This chapter shall be liberally construed to effect its purpose as provided under section 508C.2.

87 Acts, ch 223, §4

508C.5 Definitions.

As used in this chapter, unless the context otherwise requires:

1. *"Account"* means any of the four accounts created under section 508C.6.

2. *"Association"* means the Iowa life and health insurance guaranty association created in section 508C.6.

3. *"Authorized assessment"*, or the term *"authorized"* when used in the context of an assessment, means that a resolution has been passed by the board of directors of the association whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

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

5. *"Called assessment"*, or the term *"called"* when used in the context of an assessment, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

6. *"Commissioner"* means the commissioner of insurance.

7. *"Contractual obligation"* means an obligation under a covered policy or contract or a certificate under a group policy or contract, or a portion thereof for which coverage is provided under section 508C.3.

8. *"Covered policy"* or *"covered contract"* means a policy or contract, or a portion of a policy or contract, for which coverage is provided under section 508C.3.

9. *"Extra-contractual claim"* means, without limitation, a claim relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney fees and costs.

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

a. Accident-only insurance.

b. Credit insurance.

c. Dental-only insurance.

d. Vision-only insurance.

e. Medicare supplement insurance.

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

g. Disability income insurance.

h. Coverage for an onsite medical clinic.

i. Specified disease, hospital confinement indemnity, or limited benefit health insurance if the specific type of coverage does not provide coordination of benefits and is provided under a separate policy or certificate.

11. *"Impaired insurer"* means a member insurer which is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

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

13. *"Member insurer"* means an insurer or health maintenance organization which is licensed or which holds a certificate of authority to transact in this state any kind of insurance or health maintenance business for which coverage is provided under section 508C.3, and including an insurer or health maintenance organization whose license or certificate of authority in this state has been suspended, revoked, not renewed, or voluntarily withdrawn but does not include any of the following:

a. An entity which is a licensed company specified in section 508C.3, subsection 4, paragraph *"f"* or *"g"*.

b. A mandatory state pooling plan.

c. A mutual assessment company or other person which operates on an assessment basis.

d. An insurance exchange.

e. An entity which issues a charitable gift annuity under chapter 508F.

f. An entity whose only business in this state is operating as a managed care organization. For purposes of this paragraph, *"managed care organization"* means an entity that is under contract with the Iowa department of human services to provide services to Medicaid recipients and that also meets the definition of *"health maintenance organization"* in section 514B.1.

g. An entity similar to any of the entities enumerated in this subsection.

14. *"Moody's corporate bond yield average"* means the monthly average corporate bond yields published by Moody's investors service, inc., or any successor thereto.

15. *"Owner"* of a policy of contract, *"policy holder"*, *"policy owner"*, or *"contract owner"* means the person who is identified as the legal owner of a policy or contract under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. *"Owner"*, *"policy holder"*, *"policy owner"*, or *"contract owner"* does not include a person with a mere beneficial interest in a policy or contract.

16. *"Person"* means an individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership, association, or any other legal entity.

17. *"Plan sponsor"* means any of the following:

a. The employer in the case of a benefit plan established or maintained by a single employer.

b. The employee organization in the case of a benefit plan established or maintained by an employee organization.

c. In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

18. *"Premium"* means amounts or consideration, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. *"Premium"* does not include amounts for consideration received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under section 508C.3, subsection 4, except that assessable premium shall not be reduced on account of the provisions of section 508C.3, subsection 4, paragraph *"a"*, relating to interest limitations and section 508C.3, subsection 5, paragraph *"a"*, subparagraph (2), subparagraph division (a), relating to limitations with respect to one individual, one participant, and one policy or contract owner. *"Premium"* shall not include any of the following:

a. Premiums in excess of five million dollars on an unallocated annuity contract not issued under a governmental retirement plan, or its trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code.

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

19. *"Principal place of business"* of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function as determined pursuant to section 508C.8A.

20. *"Receivership court"* means a court in an insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insolvent or impaired insurer.

21. *"Resident"* means a person to whom a contractual obligation is owed and who resides in a state on the date of entry of a court order that determines a member insurer is an impaired insurer or a court order that determines a member insurer is an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be the state of that person's principal place of business. A citizen of the United States who is a resident of a foreign country, or is a resident of a United States possession, territory, or protectorate that does not have an association similar to the association created by this chapter, shall be deemed a resident of the state or domicile of the member insurer that issued the policy or contract.

22. *"State"* means a state, the District of Columbia, Puerto Rico, or a United States possession, territory, or protectorate.

23. *"Structured settlement annuity"* means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injuries suffered by the plaintiff or other claimant.

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

25. *"Unallocated annuity contract"* means a guaranteed investment contract, deposit administration contract, or any other annuity contract which 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 such a contract or certificate.

87 Acts, ch 223, §5; 88 Acts, ch 1135, §4 – 6; 90 Acts, ch 1234, §19, 20; 98 Acts, ch 1057, §7; 2010 Acts, ch 1063, §8 – 15; 2011 Acts, ch 70, §8 – 11; 2019 Acts, ch 12, §7, 8, 35, 36

Referred to in §507A.4, 513D.1

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

508C.6 Creation of association.

1. A nonprofit legal entity is created to be known as the Iowa life and health insurance guaranty association. All member insurers shall be and shall remain members of the association as a condition of their authority to transact insurance or health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under section 508C.10 and shall exercise its powers through the board of directors established in section 508C.7. For purposes of administration and assessment, the association shall maintain all of the following accounts:

a. A health account.

b. A life insurance account.

c. An annuity account, which shall include annuity contracts owned by a governmental retirement plan, or the plan's trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities.

d. An unallocated annuity contract account, which shall exclude contracts owned by a governmental retirement benefit plan, or the plan's trustee, established under section 401, 403(b), or 457 of the United States Internal Revenue Code.

2. The association is subject to the immediate supervision of the commissioner and the applicable provisions of the insurance laws of this state.

87 Acts, ch 223, §6; 88 Acts, ch 1135, §7, 8; 2008 Acts, ch 1123, §15; 2019 Acts, ch 12, §9, 35, 36

Referred to in §508C.5, 508C.9

2019 amendment applies beginning March 29, 2019; 2019 Acts, ch 12, §35, 36

508C.7 Board of directors.

1. The board of directors of the association shall consist of not less than seven nor more than eleven member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers, subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

2. In approving selections or in appointing members to the board, the commissioner shall consider, among other factors, whether all member insurers, including member insurers that primarily write life insurance, annuity contracts, or health benefit plans, are fairly represented.

3. At the option of the association, members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors. However, members of the board shall not otherwise be compensated by the association for their services.

87 Acts, ch 223, §7; 2019 Acts, ch 12, §10, 35, 36

Referred to in §508C.6, 508C.10

2019 amendment applies beginning March 29, 2019; 2019 Acts, ch 12, §35, 36

508C.8 Powers and duties of association.

1. If a member insurer is an impaired insurer, the association, subject to conditions imposed by the association and approved by the impaired insurer and the commissioner, may take any of the following actions:

a. Guarantee, assume, reissue, reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the covered policies or contracts of the impaired insurer.

b. Provide moneys, pledges, notes, guarantees, or other means as proper to effectuate paragraph "*a*" and assure payment of the contractual obligations of the impaired insurer pending action under paragraph "*a*".

c. Loan money to the impaired insurer and guarantee borrowings by the impaired insurer,

provided the association has concluded, based on reasonable assumptions, that there is a likelihood of repayment of the loan and a probability that unless a loan is made the association would incur substantial liabilities under subsection 2.

2. If a member insurer is an insolvent insurer, the association may in its discretion do any of the following:

a. The association may do either of the following:

(1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured the covered policies or contracts of an insolvent insurer.

(2) Assure payment of the contractual obligations of the insolvent insurer.

b. Provide moneys, pledges, notes, guarantees, or other means as reasonably necessary to discharge the association's duties described in this subsection.

c. Provide benefits and coverages in accordance with all of the following provisions:

(1) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred as follows:

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

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

(2) Make diligent efforts to provide all known insureds, enrollees, or annuitants, for nongroup policies or contracts, or group policy or contract owners, with respect to group policies or contracts, thirty days' notice of the termination, pursuant to subparagraph (1), of the benefits provided.

(3) With respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, substitute coverage on an individual basis in accordance with the provisions of subparagraph (4), if the insureds, enrollees, or annuitants had a right under law or under the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the member insurer had no right to unilaterally make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

(4) In providing the substitute coverage required under subparagraph (3), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates.

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

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

(5) Alternative policies or contracts adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

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

(b) Any alternative policy or contract issued by the association shall provide coverage of

a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(6) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to approval of the commissioner.

(7) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract, shall cease on the date the coverage, policy, or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association.

(8) When proceeding under this paragraph *"c"* with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 508C.3, subsection 4, paragraph *"a"*.

(9) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy, contract, or substitute coverage shall terminate the association's obligations under the policy, contract, or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due under this chapter.

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

(11) The protection provided by this chapter shall not apply where any guaranty protection is provided to a resident of this state by the laws of the domiciliary state or by jurisdiction of the impaired or insolvent insurer by an entity other than this state.

3. *a.* In carrying out its duties under subsection 2, permanent policy liens or contract liens may be imposed in connection with a guarantee, assumption, or reinsurance agreement, if the court does both of the following:

(1) Finds either that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the insolvent insurer's contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to the public interest to justify the imposition of policy or contract liens.

(2) Approves the specific policy liens or contract liens to be used.

b. Before being obligated under subsection 2, the association may request the imposition of a temporary moratorium, not exceeding three years, or liens on payments of cash values, termination values, and policy loans in addition to any contractual provisions for deferral of cash values, termination values, or policy loans. The temporary moratoriums and liens may be imposed by the court as a condition of the association's liability with respect to the insolvent insurer.

c. The obligations of the association under subsection 2 regarding a covered policy shall be reduced to the extent that the person entitled to the obligations has received payment of all or any part of the contractual benefits payable under the covered policy from any other source.

d. The association may offer modifications to the owners of policies or contracts or classes of policies or contracts issued by the insolvent insurer, if the association finds that under the policies or contracts the benefits provided, provisions pertaining to renewal, or the premiums charged or which may be charged are not reasonable. If the owner of a policy or contract to be modified fails or refuses to accept the modification as approved by the court, the association may terminate the policy or contract as of a date not less than one hundred eighty days after the modification is sent to the owner. The association shall have no liability under the policy or contract for any claim incurred or continuing beyond the termination date. However, this paragraph does not apply to interest adjustments made pursuant to section 508C.3, subsection 4, paragraph *"a"*.

4. If the association fails to act within a reasonable period of time as provided in subsection 2, the commissioner shall have the powers and duties of the association under this chapter with respect to insolvent insurers.

5. Upon request the association may give assistance and advice to the commissioner concerning the rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

6. *a.* The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association including but not limited to proposals for reinsuring, reissuing, modifying, or guaranteeing the covered policies or contracts of the impaired or insolvent insurer and the determination of the covered policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before any court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

b. As a creditor of an impaired or insolvent insurer as provided under section 508C.13, subsection 3, and consistent with the provisions of section 507C.34, the association and similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse the association or similar associations, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association or similar associations shall be entitled to make application to the receivership court for approval of the association's or the similar association's proposal to disburse the assets.

7. *a.* A person receiving benefits under this chapter is deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received under this chapter, whether the benefits are payments of contractual obligations or on account of contractual obligations, a continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to the association of the rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person. The association shall be subrogated to the rights of any enrollee, payee, policy or contract holder, beneficiary, insured, or annuitant against the assets of the impaired or insolvent insurer.

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

c. In addition to the rights pursuant to paragraphs "*a*" and "*b*", the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired insurer, insolvent insurer, owner, beneficiary, enrollee, or payee of a covered policy or covered contract with respect to the covered policy or covered contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for the annuity, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code.

d. If the provisions of paragraphs "*a*" through "*c*" are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person

with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the association.

e. If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in paragraphs "*a*" through "*d*", the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the association.

8. The association has no obligation to issue a group conversion policy of any nature to a person or to continue a group coverage in force for more than sixty days following the date the member insurer was adjudicated to be insolvent.

9. The association may do any of the following:

a. Enter into contracts as necessary or proper to carry out this chapter.

b. Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 508C.9.

c. Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association held by domestic insurers and not in default qualify as investments eligible for deposit under section 511.8, subsection 16.

d. Employ or retain persons as necessary to handle the financial transactions of the association, and to perform other functions as necessary or proper under this chapter.

e. Negotiate and contract with a liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.

f. Take legal action as necessary to avoid payment of improper claims.

g. For the purposes of this chapter and to the extent approved by the commissioner, exercise the powers of a domestic life insurer, health insurer, or health maintenance organization, but the association shall not issue policies or contracts other than those issued to perform the association's obligations under this chapter.

h. 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.

i. Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which the association provides coverage under this chapter.

j. Take other necessary or appropriate action to discharge the association's duties and obligations under this chapter or to exercise the association's powers under this chapter.

10. *a.* (1) At any time within one hundred eighty days of the date of an order of liquidation, the association may elect to succeed to the rights and obligations of a ceding member insurer that relate to policies or contracts covered, in whole or in part, by the association in each case under any reinsurance contract entered into by the insolvent insurer and its reinsurers, selected by the association. Any such assumption of rights and obligations shall be effective as of the date of the order of liquidation. The election shall be effected by the association or by the national organization of life and health insurance guaranty associations on its behalf by sending written notices, return receipt requested, to the affected reinsurers. As used in this subsection, "*date of election*" means the date of the election of the association to succeed to the rights and obligations of the ceding member insurer as provided in this subparagraph.

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

(a) Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed.

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

(3) The following provisions shall apply to reinsurance contracts so assumed by the association:

(a) The association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies or contracts covered, in whole or in part, by the association. The association may charge policies or contracts covered in part by the association, through reasonable allocation methods, the cost for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator.

(b) The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies or contracts covered, in whole or in part, by the association, provided that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid, a portion of the amount equal to the lesser of any of the following:

(i) The amount received by the association.

(ii) The excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy or contract less the retention of the insurer applicable to the loss or event.

(c) Within thirty days following the date of election, the association and each reinsurer under reinsurance contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the date of election with respect to policies or contracts covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the date of election. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any setoff for premiums unpaid for periods prior to the date of the order for liquidation, and the association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any dispute over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contract or, if the contract does not contain an arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association pursuant to subparagraph division (b), the receiver shall remit the same amounts to the association as promptly as practicable.

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

b. During the period from the date of the order of liquidation, until the date of election or, if the association does not elect to succeed to the rights and obligations of the ceding member insurer as provided in paragraph "*a*", subparagraph (1), until one hundred eighty days after the date of the order of liquidation all of the following provisions are applicable:

(1) The association and the reinsurer shall not have any rights or obligations under reinsurance contracts that the association has the right to assume under paragraph "*a*", whether for periods prior to or after the date of liquidation.

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

(3) Once the association elects to assume a reinsurance contract, the parties' rights and obligations shall be governed by the provisions of paragraph "*a*".

c. If the association does not elect to assume the rights and obligations under a reinsurance contract, the association shall have no rights or obligations in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

d. When policies or contracts, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies or contracts may also be transferred by the association, in the case of rights and obligations under reinsurance contracts assumed under paragraph "*a*", subject to the following provisions:

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

(2) The obligations described in paragraph "*a*" shall no longer apply with respect to matters arising after the effective date of the transfer.

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

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

f. Except as otherwise provided in this subsection, this subsection shall not be construed to do any of the following:

(1) Alter or modify the terms and conditions of any reinsurance contract.

(2) Abrogate or limit any rights of any reinsurer to claim that the reinsurer is entitled to rescind a reinsurance contract.

(3) Give a policyholder, contract holder, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract.

(4) Limit or affect the association's rights as a creditor of the state against the assets of this state.

(5) Apply to reinsurance agreements covering property or casualty risks.

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

12. Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

13. Venue in a suit against the association arising under this chapter shall be in the district court of Polk county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

14. In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections 1 and 2, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by the use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

a. In lieu of the index or other external reference provided for in the original policy or contract the alternative policy or contract provides for one of the following:

(1) A fixed interest rate.

(2) Payment of dividends with minimum guarantees.

(3) A different method for calculating interest or changes in value.

b. There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract.

c. The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

87 Acts, ch 223, §8; 88 Acts, ch 1135, §9; 90 Acts, ch 1234, §21, 22; 91 Acts, ch 26, §37; 92 Acts, ch 1162, §8; 2008 Acts, ch 1123, §16, 17; 2009 Acts, ch 41, §157, 158; 2010 Acts, ch 1063, §16 – 22; 2019 Acts, ch 12, §11 – 19, 35, 36; 2020 Acts, ch 1063, §275

Referred to in §508C.9, 508C.10, 508C.13

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

508C.8A Principal place of business — determination.

1. The principal place of business of a plan sponsor or a person other than a natural person shall be determined by the association in its reasonable judgment by considering all of the following factors:

a. The state in which the primary executive and administrative headquarters of the entity is located.

b. The state in which the principal office of the chief executive officer of the entity is located.

c. The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.

d. The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.

e. The state from which the management of the overall operations of the entity is directed.

2. In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the principal place of business of the entity shall be deemed to be the state in which the holding company or controlling affiliate has its principal place of business as determined by the association using the factors enumerated in subsection 1. However, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be determined to be the principal place of business of the entity.

3. In the case of a benefit plan established or maintained by two or more employers, or jointly by one or more employers and one or more employee organizations, the principal place of business of the entity shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan. In lieu of a specific or clear designation of the principal place of business of the entity under this subsection, the principal place of business of the entity shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

2011 Acts, ch 70, §12

Referred to in §508C.5

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

508C.10 Plan of operation.

1. *a.* The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments to the plan are effective upon the commissioner's written approval.

b. If the association fails to submit a suitable plan of operation or if at any time the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt rules pursuant to chapter 17A as necessary or advisable to

effectuate this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

2. All member insurers shall comply with the plan of operation.

3. In addition to other requirements established in this chapter the plan of operation shall establish all of the following:

a. Procedures for handling the assets of the association.

b. The amount and method of reimbursing members of the board of directors under section 508C.7.

c. Regular places and times for meetings of the board of directors.

d. Procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

e. Procedures for selecting the board of directors and submitting the selections to the commissioner.

f. Any additional procedures for assessments under section 508C.9.

g. Additional provisions necessary or proper for the execution of the powers and duties of the association.

4. The plan of operation may provide that any powers and duties of the association, except those under section 508C.8, subsection 9, paragraph "*c*", and section 508C.9 are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner. The delegation shall be made only to a corporation, association, or organization which extends protection at least as favorable and effective as that provided by this chapter.

87 Acts, ch 223, §10; 2019 Acts, ch 12, §23, 35, 36

Referred to in §508C.6, 508C.9

2019 amendment to subsection 1, paragraph b, applies beginning March 29, 2019; 2019 Acts, ch 12, §35, 36

508C.11 Duties and powers of commissioner.

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.

b. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties under this chapter.

2. After notice and hearing, the commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer which fails to pay an assessment when due, or fails to comply with the plan of operation. As an alternative, the commissioner may levy an administrative penalty on any member insurer which fails to pay an assessment when due. The administrative penalty shall not exceed five percent of the unpaid assessment per month. However, an administrative penalty shall not be less than one hundred dollars per month.

3. A final action of the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken within sixty days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review pursuant to chapter 17A in a court of competent jurisdiction.

4. The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of this chapter.

87 Acts, ch 223, §11; 88 Acts, ch 1112, §203; 2011 Acts, ch 70, §15, 16; 2019 Acts, ch 12, §24, 35, 36

2019 amendment applies beginning March 29, 2019; 2019 Acts, ch 12, §35, 36

508C.12 Prevention of insolvencies.

1. To aid in the detection and prevention of member insurer insolvencies or impairments the commissioner shall:

a. (1) Notify the commissioners or insurance departments of other states or territories of the United States and the District of Columbia when any of the following actions against a member insurer is taken:

(a) A license is revoked.

(b) A license is suspended.

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

(2) Notice shall be mailed to the commissioners or departments within thirty days following the earlier of when the action was taken or the date on which the action occurs. This subparagraph does not supersede section 507C.9, subsection 5.

b. Report to the board of directors when the commissioner has taken any of the actions set forth in paragraph *"a"* or has received a report from any other commissioner indicating that such action has been taken in another state. Reports to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

c. Report to the board of directors when there is reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the insurer may be an impaired or insolvent insurer.

d. Furnish to the board of directors the national association of insurance commissioners' insurance regulatory information system ratios, and listing of insurers not included in the ratios, developed by the national association of insurance commissioners, and the board may use the information in carrying out its duties and responsibilities under this section. The report and the information contained in the report shall be kept confidential by the board of directors until such time as it is made public by the commissioner or other lawful authority.

2. 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 insurers or health maintenance organizations seeking admission to transact insurance business in this state.

3. The board of directors may upon majority vote make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the solvency of an insurer or health maintenance organization seeking to transact business in this state. These reports and recommendations are not public records pursuant to chapter 22.

4. Upon majority vote, the board of directors shall notify the commissioner of any information indicating that a member insurer may be an impaired or insolvent insurer.

5. Upon majority vote, the board of directors may request that the commissioner order an examination of a member insurer which the board in good faith believes may be an impaired or insolvent insurer. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by persons designated by the commissioner. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. The examination report shall not be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection 1. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it is not a public record pursuant to chapter 22 until the release of the examination report to the public.

6. Upon majority vote, the board of directors may make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

87 Acts, ch 223, §12; 88 Acts, ch 1112, §204; 2011 Acts, ch 70, §17 – 19; 2012 Acts, ch 1023, §107; 2019 Acts, ch 12, §25 – 27, 35, 36

Referred to in §22.7(23)

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

508C.13 Miscellaneous provisions.

1. This chapter does not reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability other than the plan of this chapter.

2. Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 508C.8. Records of the negotiations or meetings shall be made public pursuant to chapter 22 only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to render a report of its activities under section 508C.14.

3. For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies or contracts reduced by any amounts to which the association is entitled pursuant to its subrogation rights under section 508C.8, subsection 7. Assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. As used in this subsection,"*assets attributable to covered policies or contracts*" means that proportion of the assets which the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

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

b. A distribution to stockholders, if any, of an impaired or insolvent insurer shall not be made until the total amount of valid claims of the association and of similar associations of other states for funds expended in carrying out its powers and duties under section 508C.8 with respect to the member insurer have been fully recovered by the association and the similar associations.

5. *a.* Subject to the limitations of paragraphs "*b*", "*c*", and "*d*", if an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under the order may recover, on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation.

b. Distributions are not recoverable if the member insurer shows that when paid the distributions were lawful and reasonable and that the member insurer did not know and could not reasonably have known that the distributions might adversely affect the ability of the member insurer to fulfill its contractual obligations.

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

d. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

e. If a person liable under paragraph "*c*" is insolvent, all its affiliates that controlled it at

the time the dividend was paid are jointly and severally liable for a resulting deficiency in the amount recovered from the insolvent affiliate.

87 Acts, ch 223, §13; 90 Acts, ch 1234, §26; 2019 Acts, ch 12, §28, 29, 35, 36; 2020 Acts, ch 1063, §276

Referred to in **§22.7(23)**, 508C.8

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

508C.14 Examination of association — annual report.

The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner by May 1 of each year, a financial report for the preceding calendar year and a report of its activities during the preceding calendar year. The financial report shall be in a form approved by the commissioner.

87 Acts, ch 223, §14

Referred to in §508C.13

508C.15 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 the association's real property.

87 Acts, ch 223, §15

508C.16 Immunity — indemnification.

1. A member insurer and its agents and employees, the association and its agents and employees, members of the board of directors, and the commissioner and the commissioner's representatives are not liable for any action taken by them or omission by them while acting within the scope of their employment and in the performance of their powers and duties under this chapter and such immunity granted under this section shall extend to their participation in any organization of one or more state associations of similar purposes and to that organization and its agents and employees.

2. Sections 490.850 through 490.859 apply to the association.

87 Acts, ch 223, §16; 88 Acts, ch 1170, §9; 91 Acts, ch 97, §55; 2002 Acts, ch 1154, §111, 125; 2011 Acts, ch 70, §20

508C.17 Stay of proceedings — reopening default judgments.

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

87 Acts, ch 223, §17; 2011 Acts, ch 70, §21

508C.18 Prohibited advertisements.

A person, including a member insurer, agent, or affiliate of a member insurer, shall 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, an advertisement, announcement, or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter. However, this section does not apply to the association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

87 Acts, ch 223, §18; 2011 Acts, ch 70, §22; 2019 Acts, ch 12, §30, 35, 36

2019 amendment applies beginning March 29, 2019; 2019 Acts, ch 12, §35, 36

508C.18A Notice to policyholders — summary of chapter and disclosure.

1. *a.* A member insurer shall not deliver a policy or contract in Iowa to the policy owner,

contract owner, certificate holder, or enrollee unless a summary document describing the general purposes and current provisions of this chapter and containing a disclosure in compliance with subsection 2 is delivered to the policy owner, contract owner, certificate holder, or enrollee at the same time.

b. The summary document shall also be available upon request by a policy owner, contract owner, certificate holder, or enrollee.

c. The distribution, delivery, contents, or interpretation of the summary document does not guarantee that either the policy or contract, or the policy owner, the contract owner, certificate holder, or enrollee, is covered in the event of the impairment or insolvency of a member insurer.

d. The summary document shall be revised by the association and approved by the commissioner as amendments to this chapter may require. Failure to receive a summary document does not give the insurance policy or contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

2. The summary document prepared pursuant to this section shall contain a clear and conspicuous disclosure on its face. The commissioner shall establish the form and content of the disclosure which shall do all of the following:

a. State the name and address of the association and the Iowa insurance division.

b. Prominently warn the policy or contract owner, certificate holder, or enrollee that the association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state.

c. State the types of insurance policies and contracts for which the association will provide coverage.

d. State that the member insurer and the member insurer's agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage.

e. State that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage from the association when selecting an insurer or health maintenance organization.

f. Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter.

g. Provide other information as directed by the commissioner, including but not limited to sources for information about the financial condition of a member insurer provided that the information is not proprietary and is subject to disclosure under chapter 22.

3. A member insurer shall retain evidence of compliance with the provisions of this section for as long as the policy or contract for which the notice is given remains in effect.

2011 Acts, ch 70, §23; 2019 Acts, ch 12, §31 – 33, 35, 36
2019 amendments apply beginning March 29, 2019; 2019 Acts, ch 12, §35, 36

508C.19 Credits for assessments paid.

1. An insurer may offset an assessment made pursuant to section 508C.9 against its premium tax liability pursuant to chapter 432 to the extent of twenty percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If an insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

2. Sums acquired by refund from the association which have been written off by contributing insurers and offset against premium taxes as provided in subsection 1 and are not then needed for purposes of this chapter shall be paid by the association to the commissioner. The commissioner shall remit the moneys to the treasurer of state to deposit in the state general fund.

87 Acts, ch 223, §19