

Chapter 74

(Senate Bill 186)

AN ACT concerning

Life and Health Insurance Guaranty Corporation Act – Revisions

FOR the purpose of revising the Life and Health Insurance Guaranty Corporation Act; altering the purpose of the Act; altering the persons to whom and circumstances under which the Life and Health Insurance Guaranty Corporation is required to provide certain coverage; providing that the Act does not provide coverage to persons who acquire the right to receive certain payments; altering the policies and contracts issued by member insurers that may not be provided coverage under the Act; prohibiting coverage from being provided under the Act for certain structured settlement annuity benefits; requiring member insurers to be and remain members of the Corporation as a condition of their authority to transact certain business in the State; altering the minimum and maximum number of members of the Board of Directors of the Corporation; authorizing the Corporation to take certain action for member insurers that are impaired insurers; authorizing the Corporation to take certain action for member insurers that are insolvent insurers; requiring that certain premiums belong to and be payable at the direction of the Corporation; requiring the Corporation to provide a certain report to a certain liquidator if requested by the liquidator; providing that the Corporation is liable for certain premiums under certain circumstances; altering the matters for which the Corporation has standing to appear or intervene in certain matters; authorizing the Corporation to require a certain enrollee to assign certain rights to the Corporation; authorizing the Corporation, subject to approval of the Maryland Insurance Commissioner, to issue substitute coverage for certain policies and contracts in carrying out its duties in connection with assuming or reissuing certain policies and contracts; altering the circumstances under which the Corporation is not liable for certain care; altering the maximum amount of certain benefits for which the Corporation may become liable; altering certain contractual obligations of certain impaired or insolvent insurers for which the Corporation may become liable under certain circumstances; providing that certain benefits shall be considered as benefits from a certain contract or policy; altering the rights and obligations of a ceding member insurer to which the Corporation is authorized to elect to succeed; applying certain rights and obligations of the Corporation to certain reinsurance contracts assumed by the Corporation under certain circumstances; applying a certain calculation requirement to certain contracts assumed by the Corporation; prohibiting certain reinsurers from taking certain actions relating to reinsurance contracts under certain circumstances; authorizing reinsurance on certain contracts to be transferred by the Corporation under certain circumstances; altering the circumstances under which reinsurance on certain policies and annuities can be transferred by the Corporation; providing that certain provisions of law do not give contract owners, enrollees, or certificate holders a certain cause of action; altering the powers of the Corporation; exempting assessments related to long-term care insurance from the requirement that the

amount of certain assessments be allocated for certain purposes; requiring that a certain assessment be allocated according to a certain methodology approved by the Commissioner; authorizing a member insurer to consider certain information in determining certain rates and dividends for certain health maintenance organization business; requiring that a certain plan submitted by the Corporation be deemed approved on a certain day except under certain circumstances; altering certain duties and powers of the Commissioner; applying certain rights and obligations of the Commissioner and the Board with respect to member insurer impairments to member insurer insolvencies; altering the contributions that a court may consider before taking certain actions; altering the list of persons whose welfare a court is required to consider when making a certain determination; establishing that it is a prohibited unfair method of competition, subject to certain provisions of law, for a person to use certain protection in the sale of health maintenance organization coverage; altering the circumstances under which a member insurer or insurance producer is prohibited from delivering a certain policy or contract; providing that certain provisions of State insurance law apply to health maintenance organizations; making certain technical corrections; defining certain terms and altering certain definitions; making stylistic and conforming changes; and generally relating to the Life and Health Insurance Guaranty Corporation Act.

BY adding to

Article – Health – General
Section 19–706(o)
Annotated Code of Maryland
(2019 Replacement Volume)

BY repealing and reenacting, without amendments,

Article – Insurance
 Section 1–101(a) and (dd)
 Annotated Code of Maryland
 (2017 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, with amendments,

Article – Insurance
 Section 9–401 through 9–403, 9–405 through 9–407, 9–407.1, 9–408 through 9–412,
 and 9–414
 Annotated Code of Maryland
 (2017 Replacement Volume and 2019 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
 That the Laws of Maryland read as follows:

Article – Health – General

19–706.

(O) THE PROVISIONS OF TITLE 9, SUBTITLE 4 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article – Insurance

1–101.

(a) In this article the following words have the meanings indicated.

(dd) “Person” means an individual, receiver, trustee, guardian, personal representative, fiduciary, representative of any kind, partnership, firm, association, corporation, or other entity.

9–401.

(a) In this subtitle the following words have the meanings indicated.

(b) “Account” means:

(1) the health [insurance] account;

(2) the life insurance account; or

(3) the annuity account.

(c) “Association” means the Corporation or any similar organization that has been formed in another state that serves the same purpose as the Corporation for the other state.

(d) “Contractual obligation” means an obligation under a policy or contract or certificate under a group policy or contract for which coverage is provided under § 9–403 of this subtitle.

(e) “Corporation” means the Life and Health Insurance Guaranty Corporation.

(f) “Covered policy” **OR “COVERED CONTRACT”** means a policy or contract to which this subtitle applies.

(G) (1) “HEALTH BENEFIT PLAN” MEANS:

(I) A HOSPITAL OR MEDICAL EXPENSE POLICY OR CERTIFICATE;

(II) A HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER CONTRACT OR GROUP MASTER CERTIFICATE; OR

(III) ANY OTHER SIMILAR HEALTH CONTRACT.

(2) “HEALTH BENEFIT PLAN” DOES NOT INCLUDE:

(I) ACCIDENT–ONLY INSURANCE;

(II) CREDIT INSURANCE;

(III) DENTAL–ONLY INSURANCE;

(IV) VISION–ONLY INSURANCE;

(V) MEDICARE SUPPLEMENT INSURANCE;

(VI) BENEFITS FOR LONG–TERM CARE, HOME HEALTH CARE, COMMUNITY–BASED CARE, OR ANY COMBINATION OF THESE BENEFITS;

(VII) DISABILITY INSURANCE;

(VIII) COVERAGE FOR ON–SITE MEDICAL CLINICS; OR

(IX) SPECIFIED DISEASE, HOSPITAL CONFINEMENT INDEMNITY, OR LIMITED BENEFIT HEALTH INSURANCE IF THE TYPES OF COVERAGE:

1. DO NOT PROVIDE COORDINATION OF BENEFITS; AND

2. ARE PROVIDED UNDER SEPARATE POLICIES OR CERTIFICATES.

[(g)] (H) “Impaired insurer” means **[an] A MEMBER** insurer that:

(1) after July 1, 1971, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction; or

(2) is determined by the Commissioner after July 1, 1971, to be unable or potentially unable to fulfill its contractual obligations.

[(h)] (I) “Individual” means a natural person covered under an individual policy **OR CONTRACT** or covered as a member **OR AN ENROLLEE** under a group policy **OR CONTRACT**.

[(i)] (J) “Insolvent insurer” means a member insurer that, after July 1, 1971, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

[(j)] (K) (1) “Member insurer” means an authorized insurer **[that writes a]** **OR A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED OR THAT HOLDS A CERTIFICATE OF AUTHORITY TO TRANSACT IN THE STATE ANY** kind of insurance **OR HEALTH MAINTENANCE ORGANIZATION BUSINESS** to which this subtitle applies.

(2) “Member insurer” includes an insurer **OR A HEALTH MAINTENANCE ORGANIZATION** whose license or certificate of authority in the State may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(3) “Member insurer” does not include:

(i) **[a health maintenance organization;**

(ii) **] a fraternal benefit society;**

[(iii)] (II) a mandatory State pooling plan;

[(iv)] (III) a mutual assessment company or other entity that operates on an assessment basis; or

[(v)] (IV) an insurance exchange.

[(k)] (L) “Moody’s corporate bond yield average” means the monthly average yield on corporate bonds as published by Moody’s Investors Service, Inc.

(M) (1) “OWNER” MEANS THE OWNER OR HOLDER OF A POLICY OR CONTRACT WHO IS:

(I) IDENTIFIED AS THE LEGAL OWNER UNDER THE TERMS OF THE POLICY OR CONTRACT OR WHO IS OTHERWISE VESTED WITH LEGAL TITLE TO THE POLICY OR CONTRACT THROUGH A VALID ASSIGNMENT COMPLETED IN ACCORDANCE WITH THE TERMS OF THE POLICY OR CONTRACT; AND

(II) PROPERLY RECORDED AS THE OWNER OF THE POLICY OR CONTRACT ON THE BOOKS OF THE MEMBER INSURER.

(2) “OWNER” DOES NOT INCLUDE A PERSON WHO HAS ONLY A BENEFICIAL INTEREST IN A POLICY OR CONTRACT.

(N) “PERSON” INCLUDES A AN INDIVIDUAL, A CORPORATION, A LIMITED LIABILITY COMPANY, A PARTNERSHIP, AN ASSOCIATION, A GOVERNMENTAL BODY OR ENTITY, OR A VOLUNTARY ORGANIZATION.

[(l)] (O) (1) “Premiums” means amounts received on covered policies or contracts, less premiums, considerations, and deposits returned, and less dividends and experience credits.

(2) “Premiums” does not include amounts for policies or contracts, or for parts of policies or contracts, for which coverage is not provided under § 9–403(g) of this subtitle.

[(m)] (P) “Resident” means a person that resides in the State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer and to whom a contractual obligation is owed.

[(n)] (Q) “Structured settlement annuity” means an annuity purchased in order to fund periodic payments for a plaintiff or any other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

[(o)] (R) “Supplemental contract” means an agreement entered into for the distribution of policy or contract proceeds.

9–402.

Subject to certain limitations, the purpose of this subtitle is to protect persons specified in § 9–403(a) through (f) of this subtitle who are policy owners, contract owners, certificate holders, beneficiaries, **ENROLLEES**, payees, and assignees of life ~~insurance policies~~, health ~~insurance policies~~, annuity ~~contracts~~, and supplemental **POLICIES, PLANS, OR** contracts specified in § 9–403(g) of this subtitle against failure in the performance of contractual obligations due to the impairment or insolvency of the **MEMBER** insurer that issued the policies, **PLANS**, or contracts.

9–403.

(a) This subtitle is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident.

(b) (1) For contracts other than structured settlement annuities, subject to paragraph (2) of this subsection, coverage shall be provided under this subtitle for the policies or contracts specified in subsection (g) of this section to a person who is:

(i) a resident and an owner of or certificate holder **OR ENROLLEE** under the policy or contract; or

(ii) a nonresident and an owner of or certificate holder **OR ENROLLEE** under the policy or contract, if:

1. the **MEMBER** insurer that issued the policy or contract is domiciled in this State;

2. the state in which the nonresident resides has an insurance guaranty corporation or its equivalent similar to the Corporation established by § 9–405 of this subtitle; and

3. the nonresident is not eligible for coverage by the insurance guaranty corporation or its equivalent in the state in which the nonresident resides because the insurer **OR HEALTH MAINTENANCE ORGANIZATION** was not licensed in that state at the time specified in that state’s guaranty corporation or association law.

(2) Coverage shall be provided under this subtitle for the policies or contracts specified in paragraph (1) of this subsection to a beneficiary, assignee, or payee, **INCLUDING A HEALTH CARE PROVIDER RENDERING SERVICES COVERED UNDER HEALTH CARE INSURANCE POLICIES, CONTRACTS, OR CERTIFICATES**, of a person covered under paragraph (1) of this subsection, regardless of the person’s residence.

(c) Except as provided in subsections (a), (d), and (e) of this section, this subtitle shall provide coverage to a person who is a payee under a structured settlement annuity or beneficiary of a payee if the payee is deceased, if:

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

(ii) the payee is not a resident and:

1. the contract owner of the structured settlement annuity is a resident; or

2. A. the contract owner of the structured settlement annuity is not a resident;

B. the insurer that issued the structured settlement annuity is domiciled in this State; and

C. the state in which the contract owner resides has an association similar to the Corporation; and

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

(d) This subtitle does not provide coverage to:

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

(2) a person who otherwise would receive coverage under this subtitle, if the person is provided coverage under the laws of another state; **OR**

(3) A PERSON WHO ACQUIRES THE RIGHT TO RECEIVE PAYMENTS THROUGH A STRUCTURED SETTLEMENT FACTORING TRANSACTION, AS DEFINED IN 26 U.S.C. § 5891(C)(3)(A), REGARDLESS OF WHETHER THE TRANSACTION OCCURRED BEFORE OR AFTER THE EFFECTIVE DATE OF 26 U.S.C. § 5891(C)(3)(A).

(e) To determine coverage under this section under circumstances in which a person could be covered by the association of more than one state, whether as an owner, a payee, **AN ENROLLEE**, a beneficiary, or an assignee, this subtitle shall be construed in conjunction with other state laws to result in coverage by only one association.

(f) (1) To determine coverage under this section, a person may be a resident of only one state.

(2) To determine coverage under this section, a person shall be treated as a resident of the state of domicile of the insurer **OR HEALTH MAINTENANCE ORGANIZATION** that issued the relevant policy or contract if:

(i) the person is a citizen of the United States and is a resident of a foreign country; or

(ii) the person is a resident of a United States possession, territory, or protectorate that does not have an association similar to the Corporation.

(g) (1) Except as provided in paragraph (2) of this subsection or otherwise limited by this subtitle, coverage shall be provided under this subtitle to persons specified in subsections (b) and (c) of this section for the following policies and contracts issued by member insurers:

(i) direct, nongroup life INSURANCE, health INSURANCE, WHICH FOR THE PURPOSES OF THIS SUBTITLE INCLUDES HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER CONTRACTS AND GROUP MASTER CERTIFICATES, annuity ANNUITIES, including structured settlement annuities, and supplemental policies or contracts to any of these; or

(ii) certificates under direct, group policies or contracts, and supplemental policies or contracts to any of these.

(2) Coverage may not be provided under this subtitle for:

(i) any part of a policy or contract that is not guaranteed by the **MEMBER** insurer, or under which the risk is borne by the policyholder or contract holder;

(ii) a policy or contract of reinsurance, unless assumption certificates have been issued;

(iii) **EXCEPT FOR A PART OF A POLICY OR CONTRACT, INCLUDING A RIDER, THAT PROVIDES LONG-TERM CARE OR ANY OTHER HEALTH INSURANCE BENEFITS**, any part of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. averaged over the period of 4 years before the date on which the Corporation becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average for the 4-year period before the date on which the Corporation became obligated or, if the policy or contract was issued less than 4 years before the Corporation became obligated, for that period; or

2. on or after the date on which the Corporation becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 3 percentage points from the most recent published Moody's corporate bond yield average;

(iv) a plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

1. a multiple employer welfare arrangement, as defined in 29 U.S.C. § 1002(40);

2. a minimum premium group insurance plan;

3. a stop-loss group insurance plan; or

4. an administrative services only contract;

(v) any part of a policy or contract to the extent that it provides dividends or experience rating credits or provides that a fee or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

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

(vii) an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by an insurer under the annuity contract or group certificate, including the following contracts:

1. unallocated funding agreements;
2. unallocated annuity contract benefits;
3. deposit administration contracts; or
4. guaranteed investment contract accounts;

(viii) a policy issued by an organization as provided in § 1–202(3) of this article;

(ix) an annuity agreement issued under § 16–114 of this article;

(x) a portion of a policy or contract to the extent that the assessments required by § 9–409 of this subtitle with respect to the policy or contract are preempted by federal or state law;

(xi) an obligation that does not arise under the express written terms of the policy or contract issued by the **MEMBER** insurer to the **ENROLLEE, CERTIFICATE HOLDER, contract owner, or policy owner**, including without limitation:

1. claims made on marketing materials;
2. claims based on side letters, riders, or other documents that were issued by the **MEMBER** insurer without meeting applicable policy form **OR CONTRACT** filing or approval requirements;
3. misrepresentations of or regarding policy **OR CONTRACT** benefits;
4. extra–contractual claims; and
5. a claim for penalties or consequential or incidental damages;

(xii) subject to paragraph (3) of this subsection, a portion of a policy or contract to the extent that it provides for interest or other changes in value to be

determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or insolvent insurer under this subtitle, whichever is earlier; [or]

(xiii) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits under **ANY OF THE FOLLOWING PROVISIONS OR REGULATIONS ADOPTED UNDER ONE OF THE FOLLOWING PROVISIONS:**

1. TITLE 42, CHAPTER 7, SUBCHAPTER XVIII, Part C or Part D [of Subchapter XVIII, Chapter 7 of Title 42] of the United States Code[, commonly known as Medicare Part C & D, or any regulations adopted under it] (“MEDICARE PART C & D”);

2. TITLE 42, CHAPTER 7, SUBCHAPTER XIX OF THE UNITED STATES CODE (“MEDICAID”); OR

3. TITLE 15, SUBTITLE 3 OF THE HEALTH – GENERAL ARTICLE; OR

(XIV) A STRUCTURED SETTLEMENT ANNUITY BENEFIT TO WHICH A PAYEE, OR BENEFICIARY OF A PAYEE IF THE PAYEE IS DECEASED, HAS TRANSFERRED THE RIGHTS IN A STRUCTURED SETTLEMENT FACTORING TRANSACTION, AS DEFINED IN 26 U.S.C. § 5891(C)(3)(A), REGARDLESS OF WHETHER THE TRANSACTION OCCURRED BEFORE OR AFTER THE EFFECTIVE DATE OF 26 U.S.C. § 5891(C)(3)(A).

(3) If a policy's or contract's interest or changes in value are credited less frequently than annually, then to determine the values that have been credited and are not subject to forfeiture under this subsection, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

9–405.

(a) (1) There is a Life and Health Insurance Guaranty Corporation.

(2) The Corporation is a private, nonprofit, nonstock corporation.

(3) The Corporation is established to enable the guaranty of payment of benefits and continuation of coverages.

(b) As a condition of its authority to transact insurance **OR HEALTH MAINTENANCE ORGANIZATION** business in the State, each member insurer must be and remain a member of the Corporation.

(c) The Corporation shall:

(1) perform its functions in accordance with the plan of operation established and approved under § 9–410 of this subtitle; and

(2) exercise its powers through the Board of Directors established under § 9–406 of this subtitle.

(d) For administration and assessment purposes, the Corporation shall maintain:

(1) the health [insurance] account;

(2) the life insurance account; and

(3) the annuity account.

(e) The Corporation is under the immediate supervision of the Commissioner and subject to the applicable insurance laws of the State.

(f) Except as otherwise provided in this subtitle, the Corporation has perpetual existence and the powers, privileges, and immunities granted by the applicable provisions of the Corporations and Associations Article.

(g) (1) The Corporation is not and may not be deemed a department, unit, agency, or instrumentality of the State for any purpose.

(2) All debts, claims, obligations, and liabilities of the Corporation, whenever incurred, shall be the debts, claims, obligations, and liabilities of the Corporation only and not of the State or the State's agencies, instrumentalities, officers, or employees.

(h) (1) The money of the Corporation is not part of the General Fund of the State.

(2) The State may not budget for or provide General Fund appropriations to the Corporation.

(3) The debts, claims, obligations, and liabilities of the Corporation are not a debt of the State or a pledge of the credit of the State.

9–406.

(a) (1) The Board of Directors of the Corporation consists of at least **[five]** 7 members but not more than **[nine]** 11 members.

(2) The members of the Board shall be elected from among the member insurers.

(3) The terms of the members of the Board shall be as set by the plan of operation.

(4) A vacancy on the Board shall be filled for the remainder of the term by a majority vote of the remaining members of the Board.

(b) (1) The Board of Directors shall elect a chairman and appoint an executive committee.

(2) The Board may elect other officers.

(c) When electing members of the Board of Directors or filling vacancies on the Board, consideration shall be given to, among other things, whether all member insurers are fairly represented.

(d) A member of the Board of Directors:

(1) may be reimbursed by the Corporation for expenses incurred in carrying out duties as a member of the Board; but

(2) may not otherwise receive compensation from the Corporation for the member's service.

(e) (1) The Board of Directors has general oversight authority over funds provided under this subtitle to the Board of Directors or Corporation.

(2) At any time or in any manner as the Board may direct, a receiver, liquidator, rehabilitator, or conservator appointed under this subtitle shall make a detailed accounting of expenditures to the Board.

9-407.

(a) For a member insurer that is an impaired insurer, the Corporation, subject to any conditions imposed by the Corporation that do not impair the contractual obligations of the impaired insurer and that are approved by the Commissioner, may:

(1) guarantee, **ASSUME**, **REISSUE**, or reinsure, or cause to be guaranteed, assumed, **REISSUED**, or reinsured, any or all of the covered policies or contracts of the impaired insurer; and

(2) provide money, pledges, loans, notes, guarantees, or other appropriate means to:

(i) carry out item (1) of this subsection; and

(ii) ensure payment of the contractual obligations of the impaired insurer, pending action under item (1) of this subsection.

(b) For a member insurer that is an insolvent insurer, the Corporation may:

(1) (i) guarantee, **ASSUME**, **REISSUE**, or reinsure, or cause to be guaranteed, assumed, **REISSUED**, or reinsured, any or all of the covered policies or contracts of the insolvent insurer; or

(ii) ensure payment of the contractual obligations of the insolvent insurer; and

(2) provide money, pledges, loans, notes, guarantees, or other appropriate means to discharge the Corporation's duties under item (1) of this subsection.

(c) If the Corporation fails to act within a reasonable period of time with respect to the impaired **INSURER** or insolvent insurer, the Commissioner shall have the powers and duties of the Corporation under this subtitle.

(D) (1) PREMIUMS DUE FOR COVERAGE AFTER ENTRY OF AN ORDER OF LIQUIDATION OF AN INSOLVENT INSURER SHALL BELONG TO AND BE PAYABLE AT THE DIRECTION OF THE CORPORATION.

(2) IF THE LIQUIDATOR OF AN INSOLVENT INSURER REQUESTS, THE CORPORATION SHALL PROVIDE A REPORT TO THE LIQUIDATOR REGARDING PREMIUM COLLECTION BY THE CORPORATION.

(3) THE CORPORATION SHALL BE LIABLE FOR UNEARNED PREMIUMS DUE TO POLICY OR CONTRACT OWNERS ARISING AFTER THE ENTRY OF THE ORDER.

[(d)] (E) (1) In carrying out its duties under subsection (b) of this section, the Corporation may request that policy liens, contract liens, moratoriums on payments, or other similar means be imposed.

(2) Policy liens, contract liens, moratoriums on payments, or other similar means may be imposed if the Commissioner approves the specific policy liens, contract liens, moratoriums on payments, or other similar means after finding that:

(i) the amounts that can be assessed under this subtitle are less than the amounts needed to ensure full and prompt performance of the impaired insurer's contractual obligations; or

(ii) the economic or financial conditions, as they affect member insurers, are sufficiently adverse to render the imposition of policy liens, contract liens, moratoriums on payments, or other similar means to be in the public interest.

(3) (i) Before being obligated under subsection (b) of this section, the Corporation may request that temporary moratoriums or liens on payments of cash values and policy loans be imposed.

(ii) If the Commissioner approves, the temporary moratoriums or liens requested by the Corporation under this paragraph may be imposed.

[(e)] (F) The Corporation is not liable under this section for a covered policy of a foreign insurer or alien insurer whose domiciliary jurisdiction or state of entry provides, by statute or regulation, protection for residents of this State substantially similar to that provided under this subtitle for residents of other states.

[(f)] (G) On request of the Commissioner, the Corporation may give help and advice to the Commissioner about rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of an impaired insurer.

[(g)] (H) (1) The Corporation has standing to appear or intervene before any court or agency with jurisdiction over an impaired **INSURER** or insolvent insurer as to which the Corporation is or may become obligated under this subtitle.

(2) The standing extends to all matters germane to the powers and duties of the Corporation, including proposals for reinsuring, **REISSUING**, **MODIFYING**, or guaranteeing the covered policies of the impaired **INSURER** or insolvent insurer and the determination of the covered policies and contractual obligations.

[(h)] (I) (1) A person receiving benefits under this subtitle, whether the benefits are payments of contractual obligations or continuation of coverage, is deemed to have assigned all rights under or causes of action relating to the covered policy to the Corporation to the extent of the benefits received because of this subtitle.

(2) The Corporation may require a payee, **ENROLLEE**, policy or contract owner, beneficiary, insured, or annuitant to assign to the Corporation all rights to the extent of benefits received under the covered policy as a condition precedent to the receipt of any rights or benefits under this subtitle.

(3) The Corporation is subrogated to the rights assigned under this subsection against the assets of the impaired **INSURER** or insolvent insurer.

(4) The subrogation rights of the Corporation under this subsection have the same priority against the assets of the impaired **INSURER** or insolvent insurer as those of the person entitled to receive benefits under this subtitle.

[(i)] (J) In carrying out its duties in connection with guaranteeing, **ASSUMING**, **REISSUING**, or reinsuring policies or contracts under subsections (a) and (b) of this section, the Corporation may, subject to approval of the Commissioner, issue substitute coverage for a policy or contract that provides an interest rate, a crediting rate, or a similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract, if:

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

- (i) a fixed interest rate;
- (ii) payment of dividends with minimum guarantees; or
- (iii) a different method for calculating interest or changes in value;

(2) there is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the original policy or contract; and

(3) the alternative policy or contract is substantially similar to the original policy or contract in all other material terms.

[(j)] (K) (1) Subject to paragraphs (2) and (3) of this subsection and unless the contractual obligations of the impaired insurer or insolvent insurer are reduced or excluded under subsection **[(d)] (E)** of this section or § 9-403(g)(2) of this subtitle, the contractual obligations of the impaired insurer or insolvent insurer for which the Corporation is or may become liable shall be as great as, but no greater than, the contractual obligations that the impaired insurer or insolvent insurer would have had in the absence of the impairment or insolvency.

(2) The Corporation is not liable for health care received after the date of the impairment or insolvency unless the health care was in progress on the date of the impairment or insolvency or unless other health care coverage is not available from another insurer, **HEALTH MAINTENANCE ORGANIZATION**, or nonprofit health service plan.

(3) Benefits for which the Corporation may become liable may not exceed the lesser of:

(i) the contractual obligations for which the **MEMBER** insurer is or would have been liable if it were not an impaired insurer or insolvent insurer; or

(ii) with respect to any one life, regardless of the number of policies or contracts:

1. \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;

2. **[in] FOR** health insurance benefits:

A. \$500,000 for **[basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans, as defined in § 15–1301 of this article] HEALTH BENEFIT PLANS;**

B. \$300,000 for disability insurance and \$300,000 for long-term care insurance, as defined in § 18–101 of this article; and

C. \$100,000 for coverages not included as **[basic hospital, medical, and surgical insurance, or major medical insurance, or] disability insurance, HEALTH BENEFIT PLANS,** or long-term care insurance, including any net cash surrender and net cash withdrawal values under items A and B of this item; and

3. A. \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; and

B. with respect to each payee under a structured settlement annuity, or beneficiary of the payee if the payee is deceased, \$250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, the Corporation may not, with respect to any one life, be liable for coverage greater than an aggregate of \$300,000 for the benefits described in paragraph (3)(ii)1, 2, and 3 of this subsection.

(ii) The Corporation may not, with respect to any one life, be liable for coverage greater than an aggregate of \$500,000 **[in basic hospital, medical, and surgical insurance or major medical insurance] FOR HEALTH BENEFIT PLANS** under paragraph (3)(ii)2A of this subsection.

[(k)] (L) The Corporation may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the Corporation.

(M) IN THIS SUBTITLE, 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 RIDER RELATES.

9-407.1.

(a) At any time within 180 days after the date of an order of liquidation, the Corporation may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, **CONTRACTS**, or annuities covered, in whole or in part, by the Corporation, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Corporation.

(b) Any assumption under subsection (a) of this section is effective as of the date of the order of liquidation.

(c) The election shall be effected by the Corporation or the National Organization of Life and Health Insurance Guaranty Associations on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(d) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available on request to the Corporation 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:

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

(2) notices of any defaults under the reinsurance contracts or any known event or condition that, with the passage of time, could become a default under the reinsurance contracts.

(e) (1) This subsection applies to reinsurance contracts assumed by the Corporation.

(2) The Corporation is responsible for all unpaid premiums due under a reinsurance contract assumed by the Corporation for periods both before and after the date of the order of liquidation, and is responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, **CONTRACTS**, or annuities covered, in whole or in part, by the Corporation.

(3) The Corporation may charge policies, **CONTRACTS**, or annuities covered in part by the Corporation, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Corporation and shall provide notice and an accounting of these charges to the liquidator.

(4) The Corporation is entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, **CONTRACTS**, or annuities covered, in whole or in part, by the Corporation, if on receipt of any amounts payable, the Corporation is obliged to pay to the beneficiary under the policy, **CONTRACT**, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(i) the amount received by the Corporation; and

(ii) the excess of the amount received by the Corporation over the amount equal to the benefits paid by the Corporation on account of the policy, **CONTRACT**, or annuity less the retention of the insurer applicable to the loss or event.

(f) (1) (i) Within 30 days after the Corporation's election, the Corporation and each reinsurer under contracts assumed by the Corporation shall calculate the net balance due to or from the Corporation under each reinsurance contract as of the election date with respect to policies, **CONTRACTS**, or annuities covered, in whole or in part, by the Corporation.

(ii) The calculation under subparagraph (i) of this paragraph shall give full credit to all items paid by either the **MEMBER** insurer or its receiver or the reinsurer prior to the election date.

(2) Within 5 days after the completion of the calculation under paragraph (1) of this subsection, the reinsurer shall pay the receiver any amounts due for losses or events before the date of the order of liquidation, subject to any setoff for premiums unpaid for periods before the date, and the Corporation or reinsurer shall pay any remaining balance due the other, in each case.

(3) Any disputes over the amounts due to either the Corporation or the reinsurer shall be resolved by arbitration under the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law.

(4) If the receiver has received any amounts due to the Corporation under subsection (e)(4) of this section, the receiver shall remit those amounts to the Corporation as promptly as practicable.

(g) If the Corporation or receiver, on the Corporation's behalf, within 60 days after the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, **CONTRACTS**, or annuities covered, in whole or in part, by the Corporation, the reinsurer is not entitled to:

(1) terminate the reinsurance contracts for failure to pay premiums for the reinsurance contracts that relate to policies, **CONTRACTS**, or annuities covered, in whole or in part, by the Corporation; or

(2) set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Corporation, against amounts due the Corporation.

(h) During the period from the date of the order of liquidation until the election date or, if the election date does not occur, until 180 days after the date of the order of liquidation:

(1) (i) neither the Corporation nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Corporation has the right to assume under subsections (a) through (g) of this section, whether for periods before or after the date of the order of liquidation; and

(ii) the reinsurer, the receiver, and the Corporation shall, to the extent practicable, provide each other data and records reasonably requested; and

(2) if the Corporation has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by subsections (a) through (g) of this section.

(i) If the Corporation does not elect to assume a reinsurance contract by the election date under subsections (a) through (g) of this section, the Corporation 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.

(j) When policies, **CONTRACTS**, or annuities, or covered obligations with respect to policies, **CONTRACTS**, or annuities, are transferred to an assuming insurer, reinsurance on the policies, **CONTRACTS**, or annuities may also be transferred by the Corporation, in the case of contracts assumed under subsections (a) through (g) of this section, if:

(1) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred does not cover any new policies of insurance, **HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER CONTRACTS AND GROUP MASTER CERTIFICATES**, or annuities in addition to those transferred;

(2) the obligations described in subsections (a) through (g) of this section no longer apply with respect to matters arising after the effective date of the transfer; and

(3) notice is given in writing, return receipt requested, by the transferring party to the affected reinsurer at least 30 days before the effective date of the transfer.

(k) (1) The provisions of this section 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.

(2) The receiver remains entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods before the date of the order of liquidation, subject to applicable setoff provisions.

(1) (1) Except as otherwise provided in this section, this section does not alter or modify the terms and conditions of any reinsurance contract.

(2) This section does not:

(i) abrogate or limit any rights of any reinsurer to claim that the reinsurer is entitled to rescind a reinsurance contract;

(ii) give a policyholder, **CONTRACT OWNER, ENROLLEE, CERTIFICATE HOLDER**, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

(iii) limit or affect the Corporation's rights as a creditor of the estate against the assets of the estate; or

(iv) apply to reinsurance agreements covering property or casualty risks.

9–408.

The Corporation may:

(1) enter into contracts that are necessary or proper to carry out the provisions and purposes of this subtitle;

(2) sue or be sued and take any other legal actions necessary or proper for the recovery of unpaid assessments under § 9–409 of this subtitle;

(3) borrow money to carry out the purposes of this subtitle, provided that any notes or other evidences of indebtedness of the Corporation not in default are legal investments for domestic insurers and may be carried as admitted assets;

(4) employ or retain persons as necessary to handle the financial transactions of the Corporation and perform other functions that are necessary or proper under this subtitle;

(5) negotiate and contract with liquidators, rehabilitators, conservators, or ancillary receivers to carry out the powers and duties of the Corporation;

(6) take any legal action necessary to avoid payment of improper claims;

(7) for the purposes of this subtitle and to the extent approved by the Commissioner, exercise the powers of a domestic life insurer [or], health insurer, **OR HEALTH MAINTENANCE ORGANIZATION**, except that the Corporation may not issue policies or [annuity] contracts other than those issued to perform the contractual obligation of an impaired **INSURER** or insolvent insurer; [and]

(8) IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE POLICY OR CONTRACT, FILE FOR ACTUARIALLY JUSTIFIED RATE OR PREMIUM INCREASES FOR ANY POLICY OR CONTRACT FOR WHICH THE CORPORATION PROVIDES COVERAGE UNDER THIS SUBTITLE; AND

~~[(8)]~~ **(9)** perform any other act necessary or proper to carry out [the purposes of] this subtitle.

9-409.

(a) Members of the Corporation are subject to assessment as provided in this section.

(b) (1) To provide the funds necessary to carry out the powers and duties of the Corporation, the Board of Directors shall assess member insurers, separately for each account, at the times and for the amounts that the Board finds necessary.

(2) The Board shall give 30 days' written notice to a member insurer before payment of an assessment is due.

(3) The Board shall collect the assessments when due.

(c) There are two classes of assessments to be made for the following purposes:

(1) Class A assessments, to be used to meet administrative costs and other general expenses not related to a particular impaired insurer or insolvent insurer; and

(2) Class B assessments, to be used to carry out the powers and duties of the Corporation with respect to an impaired insurer or insolvent insurer.

(d) (1) (i) The Board shall determine the amount of a Class A assessment.

(ii) The Board may make a Class A assessment on a pro rata or nonpro rata basis.

(iii) If made on a pro rata basis, the Board may provide that the assessment be credited against future Class B assessments.

(iv) [A nonpro rata assessment may not exceed the amount provided in the Corporation's plan of operation per member insurer in 1 calendar year.

(v) [The] **EXCEPT FOR ASSESSMENTS RELATED TO LONG-TERM CARE INSURANCE, THE** amount of a Class B assessment shall be allocated for assessment purposes among the accounts according to an allocation formula that is based on:

1. the premiums or reserves of the impaired insurer or insolvent insurer; or

2. on another standard that the Board considers in its sole discretion to be fair and reasonable under the circumstances.

(2) (I) THE AMOUNT OF A CLASS B ASSESSMENT FOR LONG-TERM CARE INSURANCE WRITTEN BY THE IMPAIRED INSURER OR INSOLVENT INSURER SHALL BE ALLOCATED ACCORDING TO A METHODOLOGY INCLUDED IN THE PLAN OF OPERATION AND APPROVED BY THE COMMISSIONER.

(II) THE METHODOLOGY USED TO ALLOCATE THE AMOUNT UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL PROVIDE FOR 50% OF THE ASSESSMENT TO BE ALLOCATED TO ACCIDENT AND HEALTH MEMBER INSURERS AND 50% TO BE ALLOCATED TO LIFE AND ANNUITY MEMBER INSURERS.

(3) The Board shall make Class B assessments against member insurers for each account in the proportion that the amount of premiums received on business in the State by each assessed member insurer on policies or contracts covered by each account for the most recent calendar year for which information is available preceding the year in which the **MEMBER** insurer became impaired or insolvent, bears to the amount of premiums received on business in the State for those calendar years by all assessed member insurers.

~~[(3)]~~ **(4)** The Board may assess member insurers on a nonpro rata basis without regard to paragraph ~~[(2)]~~ **(3)** of this subsection if the amount of a Class B assessment representing the aggregate liability of the Corporation for a single impairment or insolvency is not greater than the Class A assessment in the same calendar year against authorized insurers in the same line of business as the liability for the impaired insurer or insolvent insurer.

~~[(4)]~~ **(5)** (i) The Board may not make assessments for funds to meet the requirements of the Corporation with respect to an impaired insurer or insolvent insurer until necessary to carry out the purposes of this subtitle.

(ii) Because exact determinations may not always be possible, the Board shall make classifications of assessments and computation of assessments under this subsection with a reasonable degree of accuracy.

(e) (1) If, in the opinion of the Board, payment of an assessment would endanger the ability of a member insurer to meet its contractual obligations, the Corporation may abate or defer, wholly or partly, the assessment of the member insurer.

(2) If an assessment against a member insurer is wholly or partly abated or deferred, the amount by which the assessment is abated or deferred shall be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(f) (1) In a calendar year, the total of all assessments against a member insurer for each account may not exceed 2% of the member insurer's premiums in the State on policies covered by the account.

(2) If an assessment against a member insurer is reduced because of paragraph (1) of this subsection, the Board shall assess the amount of the reduction against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(3) If the maximum assessments in a calendar year against all **MEMBER** insurers plus the other assets of the Corporation in any account are insufficient to provide in the account the amount necessary to carry out the responsibilities of the Corporation, the Board shall make additional assessments as necessary against member insurers as soon as allowed by this subtitle.

(g) (1) If approved by the Commissioner, the Board may refund to member insurers, by an equitable method set by the plan of operation, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount that the Board finds necessary to carry out the obligations of the Corporation during the coming year.

(2) For the purpose of this subsection, assets include assets accruing from net realized gains and income from investments.

(3) If refunds are impracticable, the Board may retain a reasonable amount in an account for the continuing expenses of the Corporation and for future losses.

(h) In determining premium rates and policy owner dividends for any kind of insurance **OR HEALTH MAINTENANCE ORGANIZATION BUSINESS** within the scope of this subtitle, a member insurer may consider the amount reasonably necessary to meet its assessment obligations under this subtitle.

(i) (1) The Corporation shall issue to each member insurer that pays an assessment under this subtitle a certificate of contribution for the amount of the assessment.

(2) The certificate of contribution shall be in the form that the Commissioner requires.

(3) All outstanding certificates of contribution are of equal dignity and priority without reference to amounts or dates of issue.

(4) The member insurer may show a certificate of contribution in the member insurer's financial statement as an asset in the form and for the amount, if any, and the period of time that the Commissioner approves.

9-410.

(a) (1) (i) The Corporation shall submit to the Commissioner a plan of operation and any amendments necessary or suitable to it to ensure the fair, reasonable, and equitable administration of the Corporation.

(ii) 1. The plan of operation and any amendments to it take effect when approved in writing by the Commissioner.

2. UNLESS DISAPPROVED BY THE COMMISSIONER WITHIN 30 DAYS AFTER SUBMISSION, A PLAN OF OPERATION AND ANY AMENDMENTS TO THE PLAN SHALL BE DEEMED APPROVED ON THE 31ST DAY AFTER THE DATE ON WHICH THE PLAN WAS SUBMITTED.

(2) (i) If the Corporation fails to submit suitable amendments to the plan of operation, the Commissioner, after notice and hearing, shall adopt reasonable regulations as necessary or advisable to carry out this subtitle.

(ii) Regulations adopted under this paragraph shall continue in effect until modified by the Commissioner or superseded by an amendment to the plan of operation submitted by the Corporation and approved by the Commissioner.

(b) Each member insurer shall comply with the plan of operation.

(c) The plan of operation shall:

(1) establish procedures for handling the assets of the Corporation;

(2) establish the amounts to be reimbursed and the method of reimbursing members of the Board of Directors under § 9-406 of this subtitle;

(3) establish regular places and times for meetings of the Board of Directors;

(4) establish procedures for keeping records of the financial transactions of the Corporation, its agents, and the Board of Directors;

(5) establish procedures for choosing the Board of Directors and submitting the choices to the Commissioner;

(6) establish any additional procedures for assessments under § 9–409 of this subtitle; and

(7) contain any additional provisions necessary or proper to perform the powers and duties of the Corporation.

(d) (1) The plan of operation may provide that any or all of the powers and duties of the Corporation, except those under §§ 9–408(3) and 9–409 of this subtitle, may be delegated to a person that performs or will perform functions similar to those of the Corporation or its equivalent in two or more states.

(2) A person to which powers and duties are delegated under the plan of operation shall be:

(i) reimbursed for any payments made on behalf of the Corporation; and

(ii) paid for its performance of the functions of the Corporation.

(3) A delegation under this subsection may:

(i) take effect only with the approval of the Board of Directors and Commissioner; and

(ii) be made only to a person that extends protection not substantially less favorable and effective than that provided by this subtitle.

9–411.

(a) (1) The Commissioner:

(i) shall notify the Board of Directors of the existence of an impaired insurer not later than 3 days after a determination of impairment is made or the Commissioner receives notice of impairment;

(ii) on request of the Board of Directors, shall provide the Corporation with a statement of the premiums in the **STATE AND OTHER** appropriate states for each member insurer;

(iii) when an impairment is declared and the amount of the impairment is determined, shall serve a demand on the impaired insurer to make good the impairment within a reasonable time; and

(iv) shall be appointed as:

1. the liquidator or rehabilitator in a liquidation or rehabilitation proceeding involving a domestic **MEMBER** insurer; or

2. the conservator or ancillary receiver in a liquidation proceeding involving a member insurer that is a foreign insurer in its domiciliary jurisdiction or an alien insurer in its state of entry.

(2) (i) Notice to the impaired insurer under paragraph (1)(iii) of this subsection is deemed notice to its shareholders.

(ii) Failure of the **IMPAIRED** insurer to comply promptly with a demand to make good the impairment does not excuse the Corporation from the performance of its duties and powers under this subtitle.

(b) (1) The Commissioner:

(i) after notice and hearing, may suspend or revoke the **LICENSE OR** certificate of authority **TO TRANSACT BUSINESS IN THE STATE** of ~~a~~ **ANY** member insurer that fails to pay an assessment when due or fails to comply with the plan of operation; or

(ii) on behalf of the Corporation, may impose a penalty on a member insurer that fails to pay an assessment when due.

(2) A penalty imposed under paragraph (1)(ii) of this subsection may not exceed 5% of the unpaid assessment per month and may not be less than \$100 per month.

(c) (1) Within 30 days after an action of the Board of Directors or Corporation, a member insurer may appeal the action to the Commissioner.

(2) A final action or order of the Commissioner under this subtitle is subject to judicial review.

(d) The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of this subtitle.

9-412.

(a) (1) The Commissioner and Board of Directors have the powers and duties described in this section to help in the detection and prevention of **MEMBER** insurer impairments **OR INSOLVENCIES**.

(2) The Corporation may help the Commissioner in detecting and preventing **MEMBER** insurer impairments **OR INSOLVENCIES** as provided in this section.

(b) (1) The Commissioner shall examine a member insurer if the Commissioner has reasonable cause to believe that the member insurer may be unable or potentially unable to fulfill its contractual obligations.

(2) On a majority vote, the Board of Directors shall notify the Commissioner of any information that indicates that a member insurer may be unable or potentially unable to fulfill its contractual obligations.

(c) (1) On a majority vote, the Board of Directors may request that the Commissioner order an examination of a member insurer that the Board in good faith believes may be unable or potentially unable to fulfill its contractual obligations.

(2) The Commissioner may conduct the examination.

(3) The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by a person that the Commissioner designates.

(4) The cost of an examination shall be paid by the Corporation.

(5) The examination report shall be treated as are other examination reports.

(6) An examination report may not be released to the Board of Directors before its release to the public, but this does not excuse the Commissioner from the duty to comply with subsection (d) of this section.

(7) The Commissioner shall notify the Board of Directors when the examination is completed.

(8) (i) The request for an examination shall be kept on file by the Commissioner.

(ii) A request for examination may not be open to public inspection before the release of the examination report to the public, and shall be released at that time only if the examination discloses that the examined member insurer is unable or potentially unable to meet its contractual obligations.

(d) The Commissioner shall report to the Board of Directors when the Commissioner has reasonable cause to believe that a member insurer, examined at the request of the Board of Directors, may be unable or potentially unable to fulfill its contractual obligations.

(e) (1) On a majority vote, the Board of Directors may make reports and recommendations to the Commissioner on any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer.

(2) A report or recommendation made under this subsection is not a public document.

(f) On a majority vote, the Board of Directors may make recommendations to the Commissioner for the detection and prevention of **MEMBER** insurer impairments **OR INSOLVENCIES**.

(g) At the conclusion of [an] **A MEMBER** insurer impairment **OR INSOLVENCY** in which the Corporation carried out its duties or exercised its powers under this subtitle, the Board of Directors shall prepare and submit to the Commissioner a report on the history and causes of the impairment **OR INSOLVENCY**, based on the information available to the Corporation.

9-414.

(a) This subtitle may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired **INSURER** or insolvent insurer operating under a plan with assessment liability.

(b) Assessable premiums may not be reduced because of § 9-403(g)(2)(iii) of this subtitle relating to interest limitations and because of [§ 9-407(j)] **§ 9-407(k)** of this subtitle relating to limitations with respect to an individual policyholder.

(c) (1) The Corporation shall keep records of all negotiations and meetings in which the Corporation or its representatives are involved to discuss the activities of the Corporation in carrying out its powers and duties under §§ 9-407 and 9-408 of this subtitle.

(2) Records of the negotiations or meetings described in paragraph (1) of this subsection shall be made public only:

(i) after the termination of a liquidation, rehabilitation, or conservation proceeding involving an impaired **INSURER** or insolvent insurer;

(ii) after the termination of the impairment or insolvency of [an] **A MEMBER** insurer; or

(iii) by court order.

(3) This subsection does not limit the duty of the Corporation to submit a report of its activities under § 9-415 of this subtitle.

(d) (1) In this subsection, “assets attributable to covered policies” means that proportion of the impaired **INSURER’S** or insolvent insurer’s assets that the amount of the reserves that should have been established for the covered policies bears to the amount of the reserves that should have been established for all policies written by the impaired **INSURER** or insolvent insurer.

(2) For the purpose of carrying out its obligations under this subtitle, the Corporation is considered a creditor of the impaired **INSURER** or insolvent insurer to the extent of the impaired **INSURER’S** or insolvent insurer’s assets attributable to covered policies reduced by any amounts to which the Corporation is entitled as subrogee under [§ 9–407(h)] **§ 9–407(I)** of this subtitle.

(3) The assets attributable to covered policies of the impaired **INSURER** or insolvent insurer shall be used to continue the covered policies and pay the contractual obligations of the impaired **INSURER** or insolvent insurer as required by this subtitle.

(e) (1) (i) Before the termination of a liquidation, rehabilitation, or conservation proceeding, the court may consider the contributions of the respective parties, including the Corporation, the stockholders, **CONTRACT OWNERS, CERTIFICATE HOLDERS, ENROLLEES**, and policy owners of the impaired **INSURER** or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired **INSURER** or insolvent insurer.

(ii) In making a determination under subparagraph (i) of this paragraph, the court shall consider the welfare of the policyholders, **CONTRACT OWNERS, CERTIFICATE HOLDERS, AND ENROLLEES** of the continuing or successor **MEMBER** insurer.

(2) A distribution to any stockholders of an impaired **INSURER** or insolvent insurer may not be made until all of the assessments levied by the Corporation with respect to the impaired **INSURER** or insolvent insurer have been fully recovered by the Corporation.

(f) It is a prohibited unfair method of competition, subject to Title 27 of this article (Unfair Trade Practices), for a person to make use in any manner of the protection afforded by this subtitle in the sale of insurance **OR HEALTH MAINTENANCE ORGANIZATION COVERAGE**.

(g) (1) Subject to the limitations of paragraphs (2) and (4) of this subsection, if an order for liquidation or rehabilitation of [an] **A MEMBER** insurer domiciled in the State has been entered, the receiver appointed under the order shall have a right to recover on behalf of the **MEMBER** insurer, from any affiliate that controlled the **MEMBER** insurer, the amount of distribution, other than stock dividends paid by the **MEMBER** insurer on its capital stock, made at any time during the 5 years preceding the petition for liquidation or rehabilitation.

(2) A dividend described in paragraph (1) of this subsection is not recoverable if the **MEMBER** insurer shows that:

(i) the distribution was lawful and reasonable when paid; and

(ii) the **MEMBER** insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the **MEMBER** insurer to fulfill its contractual obligations.

(3) (i) A person that was an affiliate that controlled the **MEMBER** insurer when the distributions described in paragraph (1) of this subsection were paid is liable up to the amount of distributions the person received.

(ii) A person that was an affiliate that controlled the **MEMBER** insurer when the distributions described under paragraph (1) of this subsection were declared is liable up to the amount of distributions the person would have received if the distributions had been paid immediately.

(iii) Two or more persons that are liable with respect to the same distributions are jointly and severally liable.

(4) The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the impaired **INSURER** or insolvent insurer to pay the contractual obligations of the impaired **INSURER** or insolvent insurer.

(5) If a person liable under paragraph (3) of this subsection is insolvent, all of its affiliates that controlled it when the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(h) (1) [An] **A MEMBER** insurer or insurance producer may not deliver a policy or contract that at the time of delivery exceeds the limitations imposed by [§ 9–407(j)(3)] **§ 9–407(k)(3)** of this subtitle, or that is not subject to coverage under § 9–403 of this subtitle, unless the **MEMBER** insurer or insurance producer, before or at the time of delivery, provides the policyholder, **CERTIFICATE HOLDER, ENROLLEE**, or contract holder with a separate written notice as provided in paragraph (2) of this subsection.

(2) The notice required under this subsection shall disclose clearly and conspicuously that:

(i) the policy or contract is not covered by, or exceeds the limitations of liability applicable to, the Corporation; and

(ii) the Corporation is not a department or unit of the State, and the liabilities or debts of the Corporation are not liabilities or debts of the State.

(3) The Commissioner shall adopt regulations establishing a standard form to be used by insurance producers and **MEMBER** insurers to conform with the provisions of this subsection.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 8, 2020.