REFERENCE TITLE: life and disability insurance; insolvencies

State of Arizona
House of Representatives
Fifty-third Legislature
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2018

HB 2124

Introduced by
Representative Livingston

AN ACT

AMENDING SECTIONS 20-629, 20-681, 20-682, 20-683, 20-684, 20-685, 20-686, 20-688, 20-689, 20-690, 20-692 AND 20-1053, ARIZONA REVISED STATUTES; REPEALING SECTION 20-1056, ARIZONA REVISED STATUTES; AMENDING SECTIONS 20-1066 AND 20-1068, ARIZONA REVISED STATUTES; REPEALING SECTION 20-1069, ARIZONA REVISED STATUTES; AMENDING SECTION 20-1074, ARIZONA REVISED STATUTES; RELATING TO INSURANCE INSOLVENCIES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-629, Arizona Revised Statutes, is amended to read:

20-629. Priority of distribution; definition

A. In a delinquency proceeding against an insurer domiciled in this state, the priority of distribution of claims from the general assets of the insurer shall be determined pursuant to this section. Every claim in each class shall be paid in full or adequate funds shall be reserved for the payment before the members of the next class may receive any payment. Subclasses may not be established within any class. The order of distribution is as follows:

1. The costs and expenses of administration incurred in connection with the delinquency proceedings ~~and, in a delinquency proceeding of a health care services organization domiciled in this state, claims of providers for covered services rendered pursuant to section 20-1069, subsection A, after the organization is declared insolvent to the extent those claims are not fully funded by the plan for the risk of insolvency~~.

2. Claims of the Arizona property and casualty insurance guaranty fund established pursuant to section 20-662 and the life and disability insurance guaranty fund established pursuant to section 20-683 or a similar organization in another state to the extent the organization provides substantially similar protection with respect to the same kinds of insurance, including claims for unallocated loss adjustment expenses and general administrative costs and expenses.

3. Claims under insurance policies and contracts and guaranteed investment contracts except reinsurance, including claims under nonassessable policies for unearned premiums, claims under annuity contracts, ~~third party~~ THIRD-PARTY claims against insureds who are covered under liability insurance policies and, in a delinquency proceeding of a health care services organization that is domiciled in this state, claims of enrollees and enrollees' beneficiaries ~~including~~ AND any claim ~~that an enrollee may have because the enrollee is liable to~~ OF a provider for services that are provided pursuant to and covered by ~~the enrollee's~~ A health care plan ~~with the health care services organization~~.

4. Claims of the federal government, except those claims under paragraph 3 of this subsection and claims that are treated as secured claims.

5. Claims for compensation actually owing to employees of the insurer, other than its officers, for services rendered to the insurer. This priority is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

6. Claims of any state or local government, except those claims under paragraph 3 of this subsection and claims that are treated as secured claims.

~~7. In a delinquency proceeding of a health care services organization that is domiciled in this state, claims of providers who are required by law or agreement to hold enrollees harmless from liability for services that are provided pursuant to and covered by a health care plan.~~

~~8.~~ 7. Claims of other general creditors that do not fall within any other priority under this section.

~~9.~~ 8. Claims that are filed after the date specified for filing proofs of claim pursuant to section 20-640.

~~10.~~ 9. Claims of surplus note or certificate of contribution holders or other similar obligations and for premium refunds on assessable policies.

~~11.~~ 10. Claims of shareholders, members or other owners in that capacity.

B. In a delinquency proceeding against an insurer domiciled in this state, the priority of claims against the general assets of the insurer shall be determined pursuant to this section regardless of where the claimant resides or where the assets are located.

C. In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

D. The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits, including without limitation assets comprising the applicable separate account, in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured are not fully discharged, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, all other persons who are entitled to priority under subsection A, paragraph 3 of this section, and also claimants against other special deposits who have received smaller percentages from their respective special deposits have been paid percentages of their claims equal to the percentage paid from the special deposit, subject to the applicable terms of any variable life contract, variable annuity contract or guaranteed investment contract that is supported by a separate account to the extent it is guaranteed by the general account. This subsection shall not be applied in a manner that would reduce the value of any general account guaranty.

E. The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender the owner's security and file the owner's claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as

provided in this article or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amounts shall be conclusive. Otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

F. For the purposes of this section, "health care plan" has the same meaning prescribed in section 20-1051.

Sec. 2. Section 20-681, Arizona Revised Statutes, is amended to read:

20-681. Definitions

In this article, unless the context otherwise requires:

1. "Account" means any of the three accounts established pursuant to section 20-683.

2. "Authorized" means, when used in the context of assessments pursuant to this article, an assessment for a specified amount approved by the board of directors to be called immediately or in the future from member insurers.

3. "Called" means, when used in the context of assessments pursuant to this article, an authorized assessment for which a notice has been issued by the fund to member insurers requiring payment within the time set forth in the notice.

4. "Contractual obligation" means an obligation under a covered policy or contract for which coverage is provided pursuant to this article.

5. "Covered CONTRACT" OR "COVERED policy" means a policy or contract or part of a policy or contract for which coverage is provided pursuant to this article.

6. "Fund" means the life and disability insurance guaranty fund.

7. "HEALTH BENEFIT PLAN":

(a) MEANS A HOSPITAL OR MEDICAL EXPENSE POLICY OR CERTIFICATE, A HEALTH CARE SERVICES ORGANIZATION SUBSCRIBER CONTRACT OR ANY OTHER SIMILAR HEALTH CONTRACT.

(b) 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 OR COMMUNITY-BASED CARE, OR ANY COMBINATION THEREOF.

(vii) DISABILITY INCOME INSURANCE.

(viii) COVERAGE FOR ON-SITE MEDICAL CLINICS.

(ix) SPECIFIED DISEASE, HOSPITAL CONFINEMENT INDEMNITY OR LIMITED BENEFIT HEALTH INSURANCE IF THE TYPES OF COVERAGE DO NOT PROVIDE

COORDINATION OF BENEFITS AND ARE PROVIDED UNDER SEPARATE POLICIES OR CERTIFICATES.

~~7.~~ 8. "Impaired insurer" means a member insurer that is not an insolvent insurer and that is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

~~8.~~ 9. "Insolvent insurer" means a member insurer that is placed under an order of liquidation with a finding of insolvency by a court of competent jurisdiction.

~~9.~~ 10. "Member insurer" means an insurer OR HEALTH CARE SERVICES ORGANIZATION that holds a certificate of authority to transact in this state any kind of insurance OR HEALTH CARE SERVICES ORGANIZATION BUSINESS to which this article applies and includes an insurer OR HEALTH CARE SERVICES ORGANIZATION whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn. Member insurer does not include:

(a) A fraternal benefit society licensed under chapter 4, article 4 of this title.

(b) A hospital, medical, dental or optometric service corporation licensed under chapter 4, article 3 of this title.

(c) A prepaid dental plan organization licensed under chapter 4, article 7 of this title.

~~(d) A health care services organization licensed under chapter 4, article 9 of this title.~~

~~(e)~~ (d) A mandatory state pooling plan.

~~(f)~~ (e) A mutual assessment company or other person that operates on an assessment basis.

~~(g)~~ (f) A reciprocal insurance exchange licensed under chapter 4, article 2 of this title.

~~(h)~~ (g) An entity that is similar to any of the entities described in this paragraph.

~~10.~~ 11. "Moody's corporate bond yield average" means the monthly average corporate bond yield as published by Moody's investors service, incorporated, or any successor entity.

~~11.~~ 12. "Owner" ~~means~~ AND "POLICY HOLDER" MEAN, when used in reference to a policy or contract, the person identified as the legal owner under the terms of the policy or contract or otherwise vested with legal title to the policy or contract through a valid assignment that is completed in accordance with the terms of the policy or contract and that is properly recorded as the owner on the MEMBER insurer's books. Owner ~~does~~ AND POLICY HOLDER DO not include a person with a mere beneficial interest in a policy or contract.

~~12.~~ 13. "Premiums":

(a) Means amounts or considerations by whatever name called that are received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits.

(b) Does not include:

(i) Amounts or consideration received for policies or contracts or for parts of policies or contracts for which coverage is not provided under section 20-682, subsection C, except that assessable premium shall not be reduced under section 20-682, subsection D, paragraph 4, relating to interest limitations, and section 20-682, subsection E, paragraph 2, relating to limitations with respect to one individual, one participant and one POLICY OR contract owner.

(ii) Amounts in excess of five million dollars with respect to multiple nongroup policies of life insurance owned by one owner, regardless of the number of policies or contracts held by the owner.

~~13.~~ 14. "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer. A person may be a resident of only one state, which for a person other than a natural person shall be its principal place of business. A United States citizen who resides in a foreign country or a United States territory, possession or protectorate that does not have a fund similar to the fund established under this article shall be deemed to be a resident of the state of domicile of the MEMBER insurer that issued the policy or contract.

~~14.~~ 15. "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 injury suffered by the plaintiff or other claimant.

~~15.~~ 16. "Supplemental contract" means a written agreement that is entered into for the distribution of proceeds under a life, disability, disability income or annuity policy or contract.

~~16.~~ 17. "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Sec. 3. Section 20-682, Arizona Revised Statutes, is amended to read:

20-682. Coverage; limitations

A. This article provides coverage for the policies and contracts specified in subsection B of this section to:

1. A person who, regardless of the state where the person resides, is a beneficiary, assignee or payee, INCLUDING HEALTH CARE PROVIDERS RENDERING SERVICES COVERED UNDER THE HEALTH INSURANCE POLICIES OR CERTIFICATES, of a person covered under paragraph 2 of this subsection, except for a nonresident certificate holder under a group policy or contract.

2. A person who is the owner OR ENROLLEE of, or a certificate holder under, a policy or contract other than a structured settlement annuity and who is either:

(a) A resident.

(b) Not a resident and all of the following apply:

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

(ii) The state in which the person resides has a fund similar to the fund established under this article.

(iii) The person is not eligible for coverage by a fund in any other state because the insurer OR HEALTH CARE SERVICES ORGANIZATION was not licensed in that state at the time required by the applicable law.

3. Subject to any other limitations provided by this section, a person who is a payee or a beneficiary of a deceased payee under a structured settlement annuity specified in subsection B of this section if the payee is either:

(a) A resident, regardless of where the contract owner resides.

(b) Not a resident and all of the following apply:

(i) The contract owner of the structured settlement annuity is a resident, or the contract owner of the structured settlement annuity is not a resident but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has a fund similar to the fund established by this article.

(ii) The payee, the beneficiary and the contract owner are not eligible for coverage by the fund of the state in which they reside.

B. This article provides coverage to the persons specified in subsection A of this section for POLICIES OR CONTRACTS OF direct nongroup life~~, disability or annuity policies or contracts~~ INSURANCE, DISABILITY INSURANCE, WHICH FOR THE PURPOSES OF THIS ARTICLE INCLUDES HEALTH CARE SERVICES ORGANIZATION SUBSCRIBER CONTRACTS AND CERTIFICATES, OR ANNUITIES, and for certificates under direct group policies and contracts, and for supplemental contracts to any of these, that are issued by member insurers, except as limited by this article. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

C. This article 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 is afforded coverage by the fund of another state.

2. A person who would otherwise receive coverage under this article but who is provided coverage under the laws of any other state. This article shall be construed to avoid duplicate coverage and to result in coverage by only one state.

3. A PERSON WHO ACQUIRES RIGHTS TO RECEIVE PAYMENTS THROUGH A STRUCTURED SETTLEMENT FACTORING TRANSACTION AS DEFINED IN 26 UNITED STATES CODE SECTION 5891(c)(3)(A), REGARDLESS OF WHETHER THE TRANSACTION OCCURRED BEFORE OR AFTER THAT SECTION BECAME EFFECTIVE.

D. EXCEPT AS OTHERWISE PROVIDED IN PARAGRAPH 14 OF THIS SUBSECTION, this article does not provide coverage for:

1. Any policy or contract, or any part of any policy or contract, not guaranteed by the MEMBER insurer or under which the risk is borne by the policyholder or contract owner.

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

3. Any policy or contract issued by mutual assessment companies or other persons that operate on an assessment basis, fraternal benefit societies, hospital, medical, dental and optometric service corporations or plans, prepaid dental plan organizations, ~~health care services organizations,~~ mandatory state pooling plans, a reciprocal insurance exchange and any entity similar to any of THE entities described in this paragraph.

4. A 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:

(a) Averaged over the period of four years before the date on which the member insurer becomes an impaired insurer or insolvent insurer under this article, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired insurer or insolvent insurer under this article, whichever is earlier.

(b) On and after the date on which the member insurer becomes an impaired insurer or insolvent insurer under this article, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available.

5. A part of a policy or contract issued to a plan or program of an employer, association or other person to provide life, disability or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association or other person under any of the following:

(a) A multiple employer welfare arrangement as defined in section 3(40) of the employee retirement income security act of 1974.

(b) A minimum premium group insurance plan.

(c) A stop-loss group insurance plan.

(d) An administrative services only contract.

6. A part of a policy or contract to the extent that it provides for dividend or experience rating credits, voting rights or payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service or administration of the policy or contract.

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

8. A part of a policy or contract to the extent that the assessments required by section 20-686 with respect to the policy or contract are preempted or prohibited by federal or state law.

9. 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:

(a) Claims based on marketing materials.

(b) Claims based on side letters, riders or other documents that were issued by the MEMBER insurer without meeting applicable policy OR CONTRACT form filing or approval requirements.

(c) Misrepresentations of or regarding policy OR CONTRACT benefits.

(d) Extra-contractual claims, including claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney fees and costs.

(e) Claims for penalties or consequential or incidental damages.

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

11. An unallocated annuity contract.

12. A part of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or insolvent insurer under this article, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, for purposes of determining the values that have been credited and are not subject to forfeiture under this subsection, the interest or change in value determined by using the procedures defined in the policy or contract

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.

13. A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to 42 United States Code chapter 7, subchapter XVIII, part C or part D OR 42 UNITED STATES CODE CHAPTER 7, SUBCHAPTER XIX, or any applicable regulations.

14. 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 UNITED STATES CODE SECTION 5891(c)(3)(A), REGARDLESS OF WHETHER THE TRANSACTION OCCURRED BEFORE OR AFTER THAT SECTION BECAME EFFECTIVE.

15. THE EXCLUSION FROM COVERAGE REFERENCED IN PARAGRAPH 4 OF THIS SUBSECTION DOES NOT APPLY TO ANY PORTION OF A POLICY OR CONTRACT, INCLUDING A RIDER, THAT PROVIDES LONG-TERM CARE OR ANY OTHER HEALTH INSURANCE BENEFITS.

E. The benefits that the fund becomes or may become obligated to cover shall not exceed the lesser of:

1. The contractual obligations for which the ~~impaired insurer or insolvent~~ MEMBER insurer is liable or would have been liable if it were not an impaired insurer or insolvent insurer.

2. With respect to one life, regardless of the number of policies or contracts:

(a) 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.

(b) ~~In~~ FOR disability insurance benefits:

(i) One hundred thousand dollars for coverages not defined as disability income insurance or ~~basic hospital, medical and surgical insurance or major medical insurance~~ HEALTH BENEFIT PLANS or long-term care insurance.

(ii) Three hundred thousand dollars for disability income insurance and three hundred thousand dollars for long-term care insurance.

(iii) Five hundred thousand dollars for ~~basic hospital medical and surgical insurance or major medical insurance~~ HEALTH BENEFIT PLANS.

(c) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

3. With respect to each payee of a structured settlement annuity, or the beneficiary of a deceased payee, an aggregate of two hundred fifty thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values, if any.

F. Notwithstanding subsection E of this section, the fund is not obligated to cover more than either:

1. An aggregate of three hundred thousand dollars in benefits with respect to any one individual under subsection E of this section except with respect to benefits for ~~basic hospital, medical and surgical insurance and major medical insurance~~ HEALTH BENEFIT PLANS under subsection E, paragraph 2, subdivision (b) of this section, in which case the aggregate liability of the fund shall not exceed five hundred thousand dollars with respect to any one individual.

2. With respect to one owner of multiple nongroup policies of life insurance, whether the policy OR CONTRACT owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner.

G. The limitations set forth in this section are limitations on the benefits for which the fund is obligated, before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired insurer or insolvent insurer attributable to covered policies. The costs of the fund's obligations under this article may be met by the use of assets attributable to covered policies or reimbursed to the fund pursuant to its subrogation and assignment rights.

H. FOR THE PURPOSES OF THIS ARTICLE, 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 IT RELATES.

Sec. 4. Section 20-683, Arizona Revised Statutes, is amended to read:

20-683. Life and disability insurance guaranty fund

A. ~~There is established in the insurance department a~~ THE life and disability insurance guaranty fund IS ESTABLISHED IN THE DEPARTMENT OF INSURANCE. The fund shall be deposited in a depository designated by the director. All member insurers shall be members of the fund as a condition of their authority to transact insurance OR A HEALTH CARE SERVICES ORGANIZATION BUSINESS in this state. For THE purposes of administration and assessment, the fund shall maintain three accounts:

1. The disability ~~insurance~~ account.

2. The life insurance account.

3. The annuity account.

B. The fund ~~shall be~~ IS under the immediate supervision of the director and ~~shall be~~ IS subject to the applicable provisions of the insurance laws of this state.

C. All costs, expenses and liabilities of the fund shall be paid by the fund and shall not be a general obligation of the state.

D. All monies placed in the accounts of the fund may be expended for the purposes of this article.

Sec. 5. Section 20-684, Arizona Revised Statutes, is amended to read:

20-684. Guaranty fund board; meetings; definition

A. Subject to the powers of the director, the life and disability insurance guaranty fund shall be administered by a board of ~~nine~~ ELEVEN members. Each member of the board shall serve for a term of three years. Of the members first appointed, three shall serve for terms of one year, three shall serve for terms of two years~~,~~ and three shall serve for terms of three years.

B. The members of the board shall be appointed by the governor from a list of persons submitted to the governor by the director of insurance. In submitting selections for the board, the director shall consider whether all member insurers are fairly represented.

C. Members of the board ~~shall~~ ARE NOT ENTITLED TO receive ~~no~~ compensation and ~~shall not be entitled to~~ travel expenses as authorized by title 38, chapter 4, article 2 but ~~shall be~~ ARE entitled to be reimbursed for expenses incurred by them as members of the board from the assets of the fund.

Sec. 6. Section 20-685, Arizona Revised Statutes, is amended to read:

20-685. Powers and duties of the fund

A. If a member insurer is an impaired insurer, the fund, subject to any conditions imposed by the fund that do not impair the contractual obligations of the impaired insurer, with the approval of the director, may:

1. Guarantee, assume, REISSUE or reinsure, or cause to be guaranteed, assumed, REISSUED or reinsured, any or all of the policies or contracts of the impaired insurer.

2. Provide monies, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph 1 of this subsection and assure payment of the contractual obligations of the impaired insurer pending action pursuant to paragraph 1 of this subsection.

B. If a member insurer is an insolvent insurer, the fund, with the approval of the director, shall either:

1. Guarantee, assume, REISSUE or reinsure, or cause to be guaranteed, assumed, REISSUED or reinsured, the policies or contracts of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer, and provide monies, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the fund's obligations.

2. Provide benefits and coverage as follows:

(a) With respect to ~~life and disability insurance~~ policies and ~~annuities~~ CONTRACTS, assure payment of benefits ~~for premiums identical to the premiums and benefits, other than conversion and renewability~~

~~benefits,~~ that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(i) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five days, but not less than thirty days, after the date on which the fund becomes obligated with respect to the policies and contracts.

(ii) With respect to nongroup policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but not less than thirty days, from the date on which the fund becomes obligated with respect to the policies or contracts.

(b) Make diligent efforts to provide thirty days' notice of a termination of benefits under subdivision (a) of this paragraph to all known insureds, ENROLLEES or annuitants for nongroup policies and contracts, and group policy OR CONTRACT owners with respect to group policies and contracts.

(c) With respect to nongroup ~~life and disability insurance~~ policies and ~~annuities~~ CONTRACTS covered by the fund, make available to each known insured, ENROLLEE or annuitant, or owner if other than the insured or annuitant, and with respect to an individual WHO WAS formerly AN insured, ENROLLEE or ~~formerly an~~ annuitant under a group policy OR CONTRACT AND who is not eligible for replacement group coverage, substitute coverage on an individual basis in accordance with subdivision (d) of this paragraph, if the insureds, ENROLLEES or annuitants had a right under law or the terminated policy, CONTRACT or annuity to convert coverage to individual coverage or to continue an individual policy, CONTRACT or annuity in force until a specified age or for a specified time, during which the insurer OR HEALTH CARE SERVICES ORGANIZATION had no right unilaterally to make changes in any provision of the policy, CONTRACT or annuity or had a right only to make changes in premium by class.

(d) In providing substitute coverage under subdivision (c) of this paragraph:

(i) The fund may offer to reissue the terminated coverage or to issue an alternative policy OR CONTRACT AT ACTUARIALLY JUSTIFIED RATES, SUBJECT TO THE PRIOR APPROVAL OF THE DIRECTOR.

(ii) Any alternative or reissued policies OR CONTRACTS so offered shall be offered without requiring evidence of insurability and without any waiting period or exclusion that would not have applied under the terminated policy OR CONTRACT.

(iii) The fund may reinsure any alternative or reissued policy OR CONTRACT.

(e) Any alternative policy OR CONTRACT adopted by the fund is subject to approval by the ~~domiciliary insurance commissioner and the court presiding over the delinquency proceeding~~ DIRECTOR. The fund may adopt alternative policies OR CONTRACTS of various types for future

issuance without regard to any particular impairment or insolvency. Any alternative policy OR CONTRACT shall:

(i) Contain at least the minimum statutory provisions required in this state and provide benefits that are reasonable in relation to the premium charged. The fund shall set the premium in accordance with a table of rates that the fund 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.

(ii) Provide coverage of a type similar to that of the policy OR CONTRACT issued by the impaired insurer or insolvent insurer, as determined by the fund.

(f) If the fund elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy OR CONTRACT, the ~~fund~~ PREMIUM shall BE ACTUARIALLY JUSTIFIED AND SHALL BE set BY the ~~premium~~ FUND in accordance with the amount of insurance OR COVERAGE provided and the age and class of risk, subject to PRIOR approval of the ~~domiciliary insurance commissioner and the court presiding over the delinquency proceeding~~ DIRECTOR.

(g) The fund's obligations with respect to coverage under any policy OR CONTRACT of the impaired insurer or insolvent insurer or under any reissued or alternative policy OR CONTRACT shall cease on the date the coverage or policy OR CONTRACT is replaced by another similar policy OR CONTRACT by the policy OR CONTRACT owner, the insured, THE ENROLLEE or the fund.

(h) When proceeding under this paragraph with respect to a policy or contract carrying guaranteed minimum interest rates, the fund shall assure the payment or crediting of a rate of interest consistent with subdivision (c) of this paragraph.

C. The fund is not liable pursuant to this section for any covered policy of an impaired insurer or insolvent insurer whose domiciliary jurisdiction or state of entry provides by statute or regulation for residents of this state protection substantially similar to that provided by this article for residents of other states.

D. The fund may render assistance and advice to the director, on the director's request, concerning rehabilitation, payment of claims, continuations of coverage or the performance of other contractual obligations of any impaired insurer or insolvent insurer.

E. The fund shall have standing to appear or intervene before any court with jurisdiction over an impaired insurer or insolvent insurer concerning which the fund is or may become obligated, or over any person or property against which the fund may have rights, pursuant to this article. Such standing shall extend to all matters germane to the powers and duties of the fund, including proposals for reinsuring, REISSUING, modifying or guaranteeing the covered policies OR CONTRACTS of the

impaired insurer or insolvent insurer and the determination of the covered policies or contracts and contractual obligations.

F. Any persons receiving benefits pursuant to this article shall be deemed to have assigned their 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 fund to the extent of the benefits received whether the benefits are payments of contractual obligations, continuation of coverage or provision of substitute or alternative POLICIES, CONTRACTS OR coverages. The fund may require an assignment to the fund of such rights by any ENROLLEE, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred on such person pursuant to this article. The subrogation rights of the fund under this subsection shall have the same priority against the assets of any impaired insurer or insolvent insurer as that possessed by the person who is entitled to receive the benefits under this article. The fund shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired insurer or insolvent insurer or owner, beneficiary, ENROLLEE or payee of a policy or contract with respect to the policy or contract. If the preceding provisions of this subsection are ineffective with respect to any person or claim for any reason, the amount payable by the fund with respect to the related covered obligations shall be reduced by the amount attributable to the policies OR CONTRACTS, or any part of the policies OR CONTRACTS, covered by the fund that is realized by any other person with respect to the person or claim. If the fund has provided benefits with respect to a covered obligation and a person recovers amounts as to which the fund has rights under this subsection, the person shall pay to the fund the part of the recovery attributable to the policies OR CONTRACTS, or any part of the policies OR CONTRACTS, covered by the fund.

G. Notwithstanding any other law, the fund is not obligated to pay any amount that does not constitute a payment of a contractual obligation, including taxable costs or attorney fees that could be awarded or any additional liabilities or obligations as might otherwise exist or accrue against the impaired insurer if the insurer had not become impaired.

H. The fund may:

1. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article.

2. Sue and be sued, including taking any legal actions that are necessary and proper for recovery of any unpaid assessments pursuant to section 20-686.

3. Borrow money to effect the purposes of this article. Any notes or other evidence of indebtedness of the fund that are not in default shall be legal investments for domestic MEMBER insurers and may be carried as admitted assets.

4. Employ and retain such persons as are necessary to handle the financial transactions of the fund and perform such other functions as become necessary or proper.

5. Negotiate and contract with any liquidator, rehabilitator, conservator or ancillary receiver to carry out the powers and duties of the fund.

6. Join an organization comprised of one or more other similar state funds in order to further the administration of the fund's powers and duties under this article.

7. Take such legal action as may be necessary to avoid payment of improper claims.

8. Exercise, for the purposes of this article and to the extent approved by the director, the powers of a domestic life ~~and~~ INSURER, disability insurer OR HEALTH CARE SERVICES ORGANIZATION. In no case may the fund issue ~~insurance~~ policies or ~~annuity~~ contracts other than those issued to perform the contractual obligations of the impaired insurer or insolvent insurer.

9. UNLESS PROHIBITED BY LAW, IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE POLICY OR CONTRACT, FILE FOR ACTUARIALLY JUSTIFIED RATE OR PREMIUM INCREASES FOR ANY POLICY OR CONTRACT FOR WHICH THE FUND PROVIDES COVERAGE UNDER THIS ARTICLE.

I. At any time within one hundred eighty days after the date of the order of liquidation, the fund, by written notice to the affected reinsurers, may elect to assume the rights and obligations of a ceding member insurer that relate to policies or annuities covered in whole or in part by the fund under any one or more reinsurance contracts entered into by the insolvent insurer, subject to the following:

1. The assumption shall be effective as of the date of the order of liquidation.

2. The receiver and each reinsurer of the ceding member insurer shall make available on request to the fund after commencement of formal delinquency proceedings:

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

(b) Notices of any defaults under the reinsurance contracts or any known event or condition that may presently or subsequently constitute a default under the reinsurance contracts.

3. With respect to reinsurance contracts assumed by the fund under this subsection:

(a) The fund 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 for performance of all other obligations after the date of the order of liquidation that relate to policies, CONTRACTS or annuities covered in whole or in part by the fund. The fund may charge policies, CONTRACTS or annuities covered in part by the fund,

through reasonable allocation methods, for the costs for reinsurance in excess of the fund's obligations and shall provide notice and an accounting of these charges to the receiver.

(b) The fund shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur after the date of the order of liquidation and that relate to policies, CONTRACTS or annuities covered in whole or in part by the fund, provided that on receipt of any such amounts, the fund shall pay to the beneficiary under the policy, CONTRACT or annuity an amount equal to the lesser of:

(i) The amount received by the fund.

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

(c) Within thirty days after the fund's election, the fund and each reinsurer under contracts assumed by the fund shall calculate the net balance due to or from the fund under each reinsurance contract as of the date of the fund's election with respect to policies, CONTRACTS or annuities covered in whole or in part by the fund, giving full credit to all items paid by the member insurer or its receiver or the reinsurer before the date of the fund's election. 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 of the order of liquidation, and the fund or reinsurer shall pay any remaining balance due the other within five days after the completion of the calculation. Any disputes over the amounts due shall be resolved in accordance with the reinsurance contract. If the receiver has received any amounts due to the fund pursuant to subdivision (b) of this paragraph, the receiver shall promptly remit the amount to the fund.

(d) If the fund or receiver, within sixty days after the election, pays the unpaid premiums due for periods both before and after the election date that relate to policies, CONTRACTS and annuities covered in whole or in part by the fund, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium to the extent the reinsurance contracts ~~relate~~ RELATED to policies, CONTRACTS or annuities covered in whole or in part by the fund, and shall not be entitled to set off any unpaid amounts due under other contracts or due from parties other than the fund, against amounts payable to the fund.

4. Provided that the parties rights and obligations shall be governed by paragraph 3 of this subsection, if the fund elects to assume a reinsurance contract, during the period from the date of the order of liquidation until the earlier of the election date or one hundred eighty days after the date of the order of liquidation:

(a) The fund and the reinsurer shall not have any rights or obligations under reinsurance contracts that the fund has the right to assume under paragraph 3 of this subsection, whether for periods before or after the date of the order of liquidation.

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

5. If the fund does not elect to assume a reinsurance contract by the election date pursuant to paragraph 3 of this subsection, the fund shall have no rights or obligations with respect to the reinsurance contract for periods before and after the date of the order of liquidation.

6. If the fund transfers policies, CONTRACTS or annuities, or covered obligations with respect to policies, CONTRACTS or annuities, to an assuming insurer, reinsurance on the transferred policies, CONTRACTS or annuities may also be transferred by the fund, in the case of contracts assumed under paragraph 3 of this subsection, subject to the following:

(a) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any policies, CONTRACTS or annuities other than those transferred.

(b) The obligations described in paragraph 3 of this subsection do not apply with respect to matters arising after the date of the transfer.

(c) The transferring party shall provide written notice to the affected reinsurer not less than thirty days before the effective date of the transfer.

J. Subsection I of this section supersedes any provision of 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 contracts with respect to losses or events that occur in periods before the date of the order of liquidation, subject to any applicable setoff provisions.

K. Except as otherwise provided in subsection I of this section, this section does not:

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

2. Limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract.

3. Provide a policy owner, 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.

4. Limit or affect the fund's rights as a creditor of the estate.

5. Apply to reinsurance contracts covering property or casualty risks.

L. In carrying out its duties in connection with guaranteeing, assuming, REISSUING or reinsuring policies or contracts under subsection A or B of this section, the fund~~, subject to approval of the court presiding over the delinquency proceeding,~~ may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

1. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, or payment of dividends with minimum guarantees, or 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 replaced policy or contract.

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

M. If the fund offers to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the fund's obligations under this article, the person shall not be entitled to benefits from the fund in addition or as an alternative to those offered under the plan or arrangement.

N. Venue in a suit against the fund arising under this article shall be in the superior court of Maricopa county. The fund shall not be required to give a bond in an appeal that relates to a cause of action arising under this article.

Sec. 7. Section 20-686, Arizona Revised Statutes, is amended to read:

20-686. Assessments

A. For the purpose of providing the funds necessary to carry out the powers and duties of the fund, the fund shall assess the member insurers, separately for each account, at such times and for such amounts as the fund finds necessary. The member insurers shall be required to pay the assessments within the time prescribed in a written notice of the assessment to the member insurers but no less than thirty days after the date of the written notice.

B. There shall be two classes of assessments, as follows:

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

2. Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the fund pursuant to section 20-685 with regard to an impaired insurer or insolvent insurer.

C. The amount of assessment for each account shall be determined as follows:

1. The amount of any class A assessment for each account shall be determined by the fund.

2. The amount of any class B assessment, EXCEPT FOR ASSESSMENTS RELATED TO LONG-TERM CARE INSURANCE, shall be ~~divided among~~ ALLOCATED BETWEEN the accounts in the proportion that the premiums received by the impaired insurer or insolvent insurer on the policies OR CONTRACTS covered by each account bear to the premiums received by such insurer on all SUCH policies OR CONTRACTS. 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 AND APPROVED BY THE DIRECTOR. THE METHODOLOGY SHALL PROVIDE FOR FIFTY PERCENT OF THE ASSESSMENT TO BE ALLOCATED TO ACCIDENT AND DISABILITY MEMBER INSURERS AND FIFTY PERCENT TO BE ALLOCATED TO LIFE AND ANNUITY MEMBER INSURERS.

~~2.~~ 3. Class A and class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account bear to such premiums received on business in this state by all assessed member insurers.

~~3.~~ 4. Assessments for funds to meet the requirements of the fund with respect to an impaired insurer or insolvent insurer shall not be made until necessary to implement the purposes of this article. Classification of assessments as prescribed pursuant to subsection B of this section and computation of assessments pursuant to this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

~~4.~~ 5. The total of all assessments on a member insurer for each account shall not in any one calendar year exceed two ~~per cent~~ 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 became an impaired insurer or insolvent insurer. 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 shall be limited to the greater of the three year average annual premiums for the applicable account as calculated pursuant to this subsection.

D. The fund may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the fund, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations.

E. If an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth in subsection D of this section, the amount by which such 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. If the maximum assessment, together with the other assets of the fund in either account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the fund, the necessary additional monies shall be assessed as soon thereafter as permitted by this article.

F. The fund, by an equitable method as established in the plan of operation, may refund to member insurers, in proportion to the contribution of each MEMBER insurer to that account, the amount the fund finds is not necessary to carry out during the coming year the obligations of the fund with regard to such amount, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the fund and for future losses.

G. Any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance OR HEALTH CARE SERVICES ORGANIZATION BUSINESS within the scope of this article, may consider the amount reasonably necessary to meet its assessment obligations.

H. The fund shall issue to each MEMBER insurer paying an assessment a certificate of contribution, in a form prescribed by the director, for the amount paid. All outstanding certificates shall be of equal 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 such form and for such amount and period of time as the director may approve.

Sec. 8. Section 20-688, Arizona Revised Statutes, is amended to read:

20-688. Duties and powers of the director

A. In addition to all other duties and powers enumerated in this article, the director shall:

1. Notify the board of directors of the existence of an impaired insurer or insolvent insurer not later than three days after a determination of impairment or insolvency or the director receives notice of impairment or insolvency.

2. On request of the board of directors, provide the board with a statement of the premiums in the appropriate states for each member insurer.

3. When an impairment is declared and the amount of the impairment is determined, serve a demand on the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders. The failure of the IMPAIRED

insurer to promptly comply with such demand shall not excuse the board from the performance of its duties pursuant to this article.

B. The director may suspend or revoke, after notice and a hearing pursuant to title 41, chapter 6, article 10, the certificate of authority to transact ~~insurance~~ BUSINESS in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the director may levy a forfeiture on any member insurer that fails to pay an assessment when due. Such forfeiture shall not exceed five ~~per cent~~ PERCENT of the unpaid assessment per month, but no forfeiture may be less than one hundred dollars per month.

C. Any action of the board of directors may be appealed to the director by any member insurer within thirty days. Except as provided in section 41-1092.08, subsection H, any final action or order of the director is subject to judicial review pursuant to title 12, chapter 7, article 6.

D. The liquidator, rehabilitator or conservator of any impaired insurer or insolvent insurer may notify all interested persons of the effect of this article.

Sec. 9. Section 20-689, Arizona Revised Statutes, is amended to read:

20-689. Prevention of impairments

To aid in the detection and prevention of MEMBER insurer impairments and insolvencies:

1. The board of directors, on majority vote, shall notify the director of any information indicating that any member insurer may be unable or potentially unable to fulfill its contractual obligations.

2. The board of directors, on majority vote, may request that the director order an examination of any member insurer which the board in good faith believes may be unable or potentially unable to fulfill its contractual obligations. The director may conduct such examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by such persons as the director designates. The cost of such examination shall be paid by the fund and the examination report shall be treated as are other examination reports. The examination report shall not be released to the board of directors of the fund before its release to the public, but this shall not excuse the director from the obligation to comply with paragraph 3. The director shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the director but it shall not be open to the public and shall be released only if the examination discloses that the examined insurer is unable or potentially unable to meet its contractual obligations.

3. The director shall report to the board of directors when the director has reasonable cause to believe that any member insurer examined at the request of the board of directors may be unable or potentially unable to fulfill its contractual obligations.

4. The board of directors, on majority vote, may make reports and recommendations to the director on any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

5. The board of directors, on majority vote, may make recommendations to the director for the detection and prevention of MEMBER insurer impairments and insolvencies.

6. The board of directors, at the conclusion of any insurer impairment or insolvency in which the fund carried out its duties, shall prepare a report on the history and causes of such impairment or insolvency based on the information available to the fund and submit such report to the director.

Sec. 10. Section 20-690, Arizona Revised Statutes, is amended to read:

20-690. Financial provisions

A. Nothing in this article shall 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. Records shall be kept of all negotiations and meetings in which the fund or its representatives are involved to discuss the activities of the fund in carrying out its powers and duties. Records of such negotiations or meetings shall be made public only on the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired insurer or insolvent insurer, on the termination of the impairment or insolvency of the insurer or on the order of a court of competent jurisdiction.

C. For the purpose of carrying out its obligations pursuant to this article, the board shall be deemed to be a creditor of the impaired insurer or insolvent insurer to the extent of assets attributable to policies reduced by any amounts to which the board is entitled as subrogee. All assets of the impaired insurer or insolvent insurer attributable to policies shall be used to continue all policies and pay all contractual obligations of the impaired insurer or insolvent insurer. As used in this subsection, "assets attributable to policies" means that proportion of the assets which the reserves that should have been established for such policies OR CONTRACTS bear to the reserve that should have been established for all policies of insurance OR HEALTH BENEFIT PLANS written by the impaired insurer or insolvent insurer.

D. Before the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties including the board, the

shareholders, CONTRACT OWNERS, CERTIFICATE HOLDERS, ENROLLEES and policyowners 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 such impaired insurer or insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders, CONTRACT OWNERS, CERTIFICATE HOLDERS AND ENROLLEES of the continuing or successor MEMBER insurer. No distribution to stockholders of the assets of an impaired insurer or insolvent insurer may be made until and unless the total amount of valid claims of the fund with interest thereon for monies expended in carrying out its powers and duties under section 20-685 with respect to such insurer is fully recovered by the fund.

E. If an order for liquidation or rehabilitation of ~~an~~ A MEMBER insurer domiciled in this state has been entered, the receiver appointed under such 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 subject to the following limitations:

1. No such dividend shall be recoverable if the MEMBER insurer shows that when paid the distribution was lawful and reasonable and that the MEMBER insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the MEMBER insurer to fulfill its contractual obligations.

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

3. The maximum amount recoverable pursuant to this subsection shall be 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.

4. If any person liable pursuant to paragraph 2 is insolvent, all its affiliates that controlled it at the time the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

F. The receiver, conservator, liquidator or statutory successor of an impaired insurer or insolvent insurer is bound by a settlement of covered claims by the fund or a similar organization in another state.

Sec. 11. Section 20-692, Arizona Revised Statutes, is amended to read:

20-692. Premium tax offset

A. The board shall issue to each MEMBER insurer paying an assessment pursuant to this article a certificate of contribution, in a form prescribed by the director for the amount paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue.

B. A certificate of contribution issued to a member insurer shall be offset against its premium tax liability to this state in the amount of twenty ~~per cent~~ PERCENT of the assessment for the year of assessment and twenty ~~per cent~~ PERCENT of the assessment per year for each of the succeeding four years.

C. Notwithstanding subsection B of this section, the total amount a member insurer~~, as defined in section 20-681,~~ may offset against its premium tax liability pursuant to a certificate of contribution that is issued from 1987 through 1994 shall not exceed the following percentage amounts for each certificate of contribution, except that in no event may the total amount of the offset exceed one hundred ~~per cent~~ PERCENT of each assessment:

1. For 1991, seven ~~per cent~~ PERCENT.
2. For 1992, nine ~~per cent~~ PERCENT.
3. For 1993, eleven ~~per cent~~ PERCENT.
4. For 1994, thirteen ~~per cent~~ PERCENT.

D. ~~No~~ A MEMBER insurer may NOT offset its premium tax liability by any amount unless the assessment for which the first year credit is claimed was collected by the guaranty fund in the calendar year for which the insurer seeks to offset its taxes.

E. Beginning in 1995, the total amount that a member insurer may offset against its premium tax liability pursuant to a certificate of contribution shall be as provided in subsection B of this section, except that in no event shall the total amount of the offset exceed one hundred ~~per cent~~ PERCENT of the assessment.

Sec. 12. Section 20-1053, Arizona Revised Statutes, is amended to read:

20-1053. Application for certificate of authority

A. An application for a certificate of authority to operate as a health care services organization shall be filed with the director in a form prescribed by the director, shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

1. A copy of the articles of incorporation and all amendments to the articles.

2. A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association.

4. A copy of any contract made or to be made between any providers or persons listed in paragraph 3 and the applicant.

5. A statement generally describing the health care services organization and its health care plan or plans, facilities and personnel, as approved by the director.

6. A copy of the form of evidence of coverage to be issued to the enrollees.

7. A copy of the form of the group contract, if any, that is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant's assets, liabilities and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the director determines that additional or more recent financial information is required for the proper administration of this article.

9. A description of the proposed method of marketing the plan, a financial plan that includes a three-year projection of the initial operating results anticipated~~,~~ and a statement as to the sources of working capital as well as any other sources of funding.

10. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the director and the director's successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state, ~~upon~~ ON whom all lawful process in any legal action or proceeding against the health care services organization on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area or areas to be served, as approved by the director.

12. The fee prescribed by section 20-167.

~~13. A plan for the risk of insolvency as prescribed in section 20-1069.~~

~~14.~~ 13. Such other information as the director may require.

B. Within ten days following any significant modification of information previously furnished pursuant to subsection A of this section, a health care services organization shall file a notice of the modification with the director.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

Sec. 13. Repeal

Section 20-1056, Arizona Revised Statutes, is repealed.

Sec. 14. Section 20-1066, Arizona Revised Statutes, is amended to read:

20-1066. Rehabilitation, liquidation or conservation of health maintenance organization

A. Any rehabilitation, liquidation, or conservation of a health care services organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurer and shall be conducted as provided in chapter 3, article 4 of this title. ~~In addition to the grounds set forth in chapter 3, article 4 of this title, failure to comply with section 20-1069 constitutes a ground for the rehabilitation, liquidation or conservation of a health care services organization.~~

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

Sec. 15. Section 20-1068, Arizona Revised Statutes, is amended to read:

20-1068. Statutory construction and relationship to other laws

A. Except as they relate to an insurer or a hospital or medical service corporation, the provisions of this title are applicable to health care services organizations only as provided in this article, chapter 1 of this title, chapter 2, article 12 of this title, chapter 3, articles 1, ~~and~~ 2 AND 7 of this title, sections 20-223, 20-233, 20-234, 20-261, 20-261.01, 20-261.02, 20-261.03, 20-261.04, 20-1133, 20-1135, 20-1379 and 20-1380, section 20-1408, subsections C through K, chapter 6, article 16 of this title and chapters 11, 15, 17, 20 and 21 of this title.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

Sec. 16. Repeal

Section 20-1069, Arizona Revised Statutes, is repealed.

Sec. 17. Section 20-1074, Arizona Revised Statutes, is amended to read:

20-1074. Contract termination; duty to report; provision for continued services during insolvency; definitions

A. Each month a health care services organization shall submit to the director a list of all written provider contracts that have been terminated during the prior month. The list shall be in writing and shall include the name and address of each provider whose contract has been terminated but shall not include the reasons for termination.

B. A health care services organization shall include in its contracts with providers a statement that requires the provider to provide services to enrollees at the same rates and subject to the same terms and conditions established in the contract for the duration of the period after the health care services organization is declared insolvent, until the earliest of the following:

~~1. The expiration of the period during which the health care services organization is required to continue benefits as described in section 20-1069, subsection A.~~

~~2.~~ 1. ~~A notification from the receiver pursuant to section 20-1069, subsection F or~~ A determination by the court that the organization cannot provide adequate assurance it will be able to pay contract providers' claims for covered services that were rendered after the health care services organization is declared insolvent.

~~3.~~ 2. A determination by the court that the insolvent organization is unable to pay contract providers' claims for covered services that were rendered after the health care services organization is declared insolvent.

~~4.~~ 3. A determination by the court that continuation of the contract would constitute undue hardship to the provider.

~~5.~~ 4. A determination by the court that the health care services organization has satisfied its obligations to all enrollees under its health care plans.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

D. For the purposes of this section:

1. "Court" has the same meaning prescribed in section 20-611.

2. "Delinquency proceeding" has the same meaning prescribed in section 20-611.

Sec. 18. Effective date

This act is effective from and after December 31, 2018.