

Kentucky Revised Statutes 304.42

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304.42-010 Title.

This subtitle shall be known and may be cited as the Kentucky Life and Health Insurance Guaranty Association Act.

Effective: June 17, 1978

History: Created 1978 Ky. Acts ch. 282, sec. 1, effective June 17, 1978.

304.42-020 Purpose of subtitle.

The purpose of this subtitle is to protect the persons specified in KRS 304.42-030(1), subject to certain limitations, against failure in the performance of contractual obligations under life, health, and annuity policies, plans, or contracts specified in KRS 304.42-030(2) because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts. To provide this protection:

- (1) An association of member insurers is created to pay benefits and to continue coverages as limited by this subtitle; and
- (2) Member insurers of the association are subject to assessment to provide funds to carry out the purpose of this subtitle.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 1, effective June 27, 2019. -- Amended 1998 Ky. Acts ch. 537, sec. 1, effective July 15, 1998. -- Created 1978 Ky. Acts ch. 282, sec. 2, effective June 17, 1978.

304.42-030 Scope of subtitle.

- (1) This subtitle shall provide coverage for the policies and contracts specified in subsection (2) of this section:
 - (a) To persons who, regardless of where they reside (except for nonresident certificate holders or enrollees under group policies or contracts), are the beneficiaries, assignees, or payees, including health care providers rendering services covered under a health insurance policy, contract, or certificate, of the persons covered under paragraph (b) of this subsection.
 - (b) To persons who are the owners of or certificate holders or enrollees under such policies or contracts, other than structured settlement annuities, who:
 1. Are residents; or
 2. Are not residents, but only under the following conditions:
 - a. The member insurer which issued the policies or contracts is domiciled in this state;
 - b. The states in which the persons reside have associations similar to the association created by this subtitle; and
 - c. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.
 - (c) For structured settlement annuities covered in subsection (2) of this section, paragraphs (a) and (b) of this subsection shall not apply and this subtitle shall, except as provided in paragraphs (d) and (e) of this subsection, 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 the payee is a resident, regardless of where the contract owner resides. If the payee is not a resident, this subtitle shall provide coverage but only under both of the following conditions:
 1.
 - a. The contract owner of the structured settlement annuity is a resident; or
 - b. 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 an association similar to the association created by this subtitle; and
 2. Neither the payee, the beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.
 - (d) This subtitle shall not provide coverage to:
 1. A person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or

2. A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. sec. 5891(c)(3)(A), regardless of whether the transaction occurred before or after the section became effective.
- (e) This subtitle is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage in this subtitle is provided coverage under the laws of any other state, the person shall not be provided coverage under this subtitle. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, enrollee, beneficiary, or assignee, this subtitle shall be construed in conjunction with other state laws to result in coverage by only one (1) association.
- (2) (a) This subtitle shall provide coverage to the persons specified in subsection (1) of this section for policies and contracts of direct, nongroup life insurance, health insurance, which for purposes of this subtitle includes health maintenance organization subscriber contracts and certificates, or annuities and supplemental contracts to any of these and for certificates issued under direct group policies and contracts.
- (b) This subtitle shall not provide coverage for:
1. Any portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
 2. Any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;
 3. Except as otherwise provided in paragraph (c) of this subsection, any portion of a policy or contract to the extent that the rate of interest on which it is based:
 - a. Averaged over the period of four (4) years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's corporate bond yield average averaged for that same four (4) year period or for such lesser period if the policy or contract was issued less than four (4) years before the association became obligated; and
 - b. On and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's corporate bond yield average as most recently available;
 4. Any portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that such plan or program is self-funded or uninsured including, but not limited to,

benefits payable by an employer, association, or other person under:

- a. A multiple employer welfare arrangement as defined in 29 U.S.C. sec. 1144;
 - b. A minimum premium group insurance plan;
 - c. A stop-loss group insurance plan; or
 - d. An administrative services only contract;
5. Any portion of a policy or contract to the extent that it provides for:
- a. Dividends or experience rating credits;
 - b. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of such policy or contract; or
 - c. Voting rights;
6. Any 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 such policy or contract in this state;
7. Any unallocated annuity contract;
8. A portion of a policy or contract to the extent that the assessments required by KRS 304.42-090 with respect to the policy or contract are preempted 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, policyholder, contract owner, or policy owner, including without limitation:
- 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. Extracontractual claims; or
 - e. A claim 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. A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to:
- a. Medicare Part C or Part D, 42 U.S.C. secs. 1395w-21 to w-154;
 - b. Medicaid, 42 U.S.C. secs. 1396 to 1396w-5; or
 - c. Any regulations issued pursuant to the sections referenced in subdivision a. or b. of this subparagraph; and

12. Structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. sec. 5891(c)(3)(A), regardless of whether the transaction occurred before or after the section became effective.
- (c) The exclusion of coverage under paragraph (b)3. of this subsection shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.
- (3) (a) The benefits that the association may become obligated to cover shall in no event exceed the lesser of the contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer, or with respect to any one (1) life, regardless of the number of policies or contracts:
 1. In life insurance, three hundred thousand dollars (\$300,000) in death benefits, but not more than one hundred thousand dollars (\$100,000) net cash surrender and net cash withdrawal values for life insurance;
 2. For health insurance benefits:
 - a. One hundred thousand dollars (\$100,000) for coverages not defined as disability income insurance, health benefit plans, or long-term care insurance, including any net cash surrender and net cash withdrawal values;
 - b. Three hundred thousand dollars (\$300,000) for disability income insurance and long-term care insurance; and
 - c. Five hundred thousand dollars (\$500,000) for health benefit plans; and
 3. In annuity benefits, two hundred fifty thousand dollars (\$250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; except with respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars (\$250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values.
 - (b) In no event shall the association be obligated to cover more than:
 1. An aggregate of three hundred thousand dollars (\$300,000) in benefits with respect to any one (1) life under subparagraphs 2. and 3. of paragraph (a) of this subsection, except with respect to benefits for health benefit plans as stated in paragraph (a) of this subsection, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars (\$500,000) with respect to any one (1) individual; or
 2. With respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy 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 (\$5,000,000) in benefits, regardless of the number of policies and contracts held by the owner.

- (c) The limitations set forth in this subsection are limitations on the benefits for which the association 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 or insolvent insurer attributable to covered policies. The costs of the association's obligations under this subtitle may be met by the use of assets attributable to covered policies or reimbursed to the association in accordance with its subrogation and assignment rights.
 - (d) For purposes of 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 it relates.
- (4) In performing its obligations to provide coverage under KRS 304.42-080, the association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be performed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 2, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 49, sec. 1, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 537, sec. 2, effective July 15, 1998. -- Amended 1988 Ky. Acts ch. 282, sec. 1, effective July 15, 1988. -- Amended 1982 Ky. Acts ch. 123, sec. 17, effective July 15, 1982. -- Created 1978 Ky. Acts ch. 282, sec. 3, effective June 17, 1978.

304.42-040 Construction of subtitle.

This subtitle shall be construed to effect the purpose under KRS 304.42-020.

Effective: July 15, 1998

History: Amended 1998 Ky. Acts ch. 537, sec. 3, effective July 15, 1998. -- Created 1978 Ky. Acts ch. 282, sec. 4, effective June 17, 1978.

304.42-050 Definitions for subtitle.

As used in this subtitle:

- (1) "Account" means either of the three (3) accounts created under KRS 304.42-060;
- (2) "Association" means the Kentucky Life and Health Insurance Guaranty Association created under KRS 304.42-060;
- (3) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specific amount. An assessment is authorized when the resolution is passed;
- (4) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan;
- (5) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;
- (6) "Contractual obligation" means any obligation under a policy or contract or a certificate under a group policy or contract, or portion thereof, for which coverage is provided under KRS 304.42-030;
- (7) "Covered contract" or "covered policy" mean any policy or contract or portion of a policy or contract for which coverage is provided under KRS 304.42-030;
- (8) "Extracontractual claims" include but are not limited to claims relating to bad faith in the payment of claims, punitive or exemplary damages, and attorneys' fees and costs;
- (9) "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract, except:
 - (a) Accident-only insurance;
 - (b) Credit insurance;
 - (c) Dental-only insurance;
 - (d) Vision-only insurance;
 - (e) Medicare Supplement insurance;
 - (f) Benefits for long-term care, home health care, community-based care, or any combination thereof;
 - (g) Disability income insurance;
 - (h) Coverage for on-site medical clinics; or
 - (i) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the coverage:
 1. Does not provide coordination of benefits; and
 2. Is provided under separate policies or certificates;

- (10) "Impaired insurer" means a member insurer which, after June 17, 1978, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;
- (11) "Insolvent insurer" means a member insurer which after June 17, 1978, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;
- (12) "Member insurer" means any insurer or health maintenance organization licensed or authorized to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under KRS 304.42-030, and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:
 - (a) A nonprofit hospital, medical-surgical, dental, and health service corporation, as defined by Subtitle 32 of this chapter;
 - (b) A fraternal benefit society;
 - (c) A mandatory state pooling plan;
 - (d) An assessment or cooperative insurer or any entity that operates on an assessment basis;
 - (e) An insurance exchange;
 - (f) Any entity similar to the above; or
 - (g) A limited health service organization;
- (13) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto;
- (14) "Owner" of a policy or contract, "policyholder," "policy owner," and "contract owner" mean the person who is 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 properly recorded as the owner on the books of the member insurer. The terms "owner," "contract owner," "policyholder," and "policy owner" do not include persons with a mere beneficial interest in a policy or contract;
- (15) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization;
- (16) "Plan sponsor" means:
 - (a) The employer in the case of a benefit plan established or maintained by a single employer;
 - (b) The employee organization in the case of a benefit plan established or maintained by an employee organization; or
 - (c) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one (1) or more employers and one (1) or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan;

(17) (a) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits, and less dividends and experience credits.

(b) "Premiums" does not include:

1. Amounts or considerations received for any policies or contracts or for the portions of policies or contracts for which coverage is not provided under KRS 304.42-030(2), except that assessable premium shall not be reduced on account of KRS 304.42-030(2)(b)3. relating to interest limitations and KRS 304.42-030(3)(b) relating to limitations with respect to one (1) individual and one (1) policy or contract owner; and
2. With respect to multiple nongroup policies of life insurance owned by one (1) owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of one million dollars (\$1,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

(18) (a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise the function, determined by the association in its reasonable judgment by considering the following factors:

1. The state in which the primary executive and administrative headquarters of the entity is located;
2. The state in which the principal office of the chief executive officer of the entity is located;
3. The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;
4. The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;
5. The state from which the management of the overall operations of the entity is directed; and
6. In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) The principal place of business of a plan sponsor of a benefit plan described in subsection (16)(c) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar

group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan or question;

- (19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer;
- (20) "Resident" means any person to whom a contractual obligation is owed and who resides in this state on the date when a member insurer is determined to be an impaired or insolvent insurer, whichever occurs first. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this subtitle shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts;
- (21) "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;
- (22) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate;
- (23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract; and
- (24) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 3, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 24, sec. 1559, effective July 15, 2010. -- Amended 2002 Ky. Acts ch. 105, sec. 28, effective July 15, 2002. -- Amended 1998 Ky. Acts ch. 537, sec. 4, effective July 15, 1998. -- Amended 1988 Ky. Acts ch. 282, sec. 2, effective July 15, 1988. -- Created 1978 Ky. Acts ch. 282, sec. 5, effective June 17, 1978.

304.42-060 Creation of association -- Membership required -- Functions -- Accounts -- Supervision by commissioner.

- (1) There is created a nonprofit legal entity to be known as the Kentucky Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their license or authority to transact insurance or health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under KRS 304.42-100 and shall exercise its powers through a board of directors established under KRS 304.42-070. For purposes of administration and assessment, the association shall maintain three (3) accounts:
 - (a) The health account;
 - (b) The life insurance account; and
 - (c) The annuity account.
- (2) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 4, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 24, sec. 1560, effective July 15, 2010. -- Created 1978 Ky. Acts ch. 282, sec. 6, effective June 17, 1978.

304.42-070 Board of directors.

- (1) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one (1) vote in person or by proxy. If the board of directors is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members.
- (2) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.
- (3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1561, effective July 15, 2010. -- Created 1978 Ky. Acts ch. 282, sec. 7, effective June 17, 1978.

304.42-080 Powers and duties of association.

- (1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:
 - (a) 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; or
 - (b) Provide such monies, pledges, loans, notes, guarantees, or other means as are proper to effectuate paragraph (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.
- (2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:
 - (a)
 1. Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or
 2. Assure payment of the contractual obligations of the insolvent insurer; and
 3. Provide such monies, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge such duties; or
 - (b) Provide benefits and coverages in accordance with the following provisions:
 1. Assure payment of benefits that would have been payable under policies or contracts of the insolvent insurer, for claims incurred:
 - a. With respect to group policies and contracts, not later than the earlier of the next renewal date under such policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to such policies or contracts;
 - b. With respect to nongroup policies, contracts, and annuities not later than the earlier of the next renewal date (if any) under such policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to such policies or contracts;
 2. Make diligent efforts to provide all known insureds, enrollees, or annuitants for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts thirty (30) days' notice of the termination under subparagraph 1. of this paragraph of the benefits provided;
 3. With respect to individual policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, enrollee, or annuitant, and

with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph 4. 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 maintenance 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;

4. a. In providing substitute coverage required under subparagraph 3. of this paragraph the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates.
 - b. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.
 - c. The association may reinsure any alternative or reissued policy or contract;
5. a. Alternative policies or contracts adopted by the association shall be subject to approval by the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.
 - b. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance or coverage 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 or enrollee after the original policy or contract was last underwritten.
 - c. Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;
6. If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to approval by the commissioner; and

7. The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date such coverage, contract, or policy is replaced by another similar policy or contract by the policy or contract owner, enrollee, the insured, or the association.
- (3) When proceeding under subsection (2)(b) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with KRS 304.42-030(2)(b)3.
- (4) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract for substitute coverage shall terminate the association's obligations under such policy, contract, or coverage under this subtitle with respect to such policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this subtitle.
- (5) 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 association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.
- (6) The protection provided by this subtitle shall not apply where any guaranteed protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.
- (7) In carrying out its duties under subsection (2) of this section, the association may:
 - (a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this subtitle are less than the amounts needed to assure full and prompt performance of the association's duties under this subtitle, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest; and
 - (b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

- (8) A deposit in this state, held under law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, shall be promptly paid to the association. The association:
- (a) Shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency; and
 - (b) Shall remit to the domiciliary receiver the amount so paid to the association and retained in accordance with paragraph (a) of this subsection. Any amount so paid to the association less the amount retained by it in accordance with paragraph (a) of this subsection shall be treated as a distribution of estate assets under KRS 304.33-440 or similar provision of the state of domicile of the impaired or insolvent insurer.
- (9) If the association fails to act within a reasonable period of time with respect to an insolvent insurer as provided in subsection (2) of this section, the commissioner shall have the powers and duties of the association under this subtitle with respect to the insolvent insurer.
- (10) The association may render assistance and advice to the commissioner, upon his or her request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.
- (11) The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this subtitle or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.
- (12) (a) Any person receiving benefits under this subtitle shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent the benefits received because of this subtitle, whether benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment

to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured, enrollee, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this subtitle upon such person.

- (b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this subtitle.
 - (c) In addition to paragraphs (a) and (b) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to such policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, enrollee, or payee of the annuity, to the extent of benefits received under this subtitle against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor.
 - (d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, contracts, or portion thereof covered by the association.
 - (e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, contracts, or portion thereof covered by the association.
- (13) In addition to the rights and powers elsewhere in this subtitle, the association may:
- (a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this subtitle;
 - (b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under KRS 304.42-090 and to settle claims or potential claims against it;
 - (c) Borrow money to effect the purposes of this subtitle; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;
 - (d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as may become necessary or proper under this subtitle;
 - (e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;
 - (f) Exercise, for the purposes of this subtitle and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer, or health

maintenance organization, but in no case may the association issue policies or contracts other than those issued to perform its obligations under this subtitle;

- (g) Organize itself as a corporation or in other legal form permitted by the laws of the state;
 - (h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this subtitle with respect to the person, and the person shall promptly comply with the request;
 - (i) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this subtitle; and
 - (j) Take other necessary or appropriate action to discharge its duties and obligations under this subtitle or to exercise its powers under this subtitle.
- (14) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.
- (15) (a) At any time within one (1) year after the date on which the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of the member insurer that accrue on or after that date and that relate to policies, contracts, or annuities covered in whole or in part by the association, under any one (1) or more indemnity reinsurance agreements entered into by the member insurer as a ceding member insurer and selected by the association. The association may not exercise any such election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurer. If the association makes an election, subparagraphs 1. to 4. of this paragraph shall apply with respect to the agreements selected by the association:
1. The association shall be responsible for all unpaid premiums due under the agreements for periods both before and after the date, and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to policies, contracts, or annuities covered, in whole or in part, by the association. The association may charge policies, contracts, or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association;
 2. The association shall be entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to policies, contracts, or annuities covered by the association, in whole or in part. Upon receipt of any such amounts the association shall be 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 excess of:

- a. The amount received by the association, over
 - b. The benefits paid by the association on account of the policy, contract, or annuity less the retention of the impaired or insolvent member insurer applicable to the loss or event;
3. Within thirty (30) days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each such reinsurance agreement as of the date of the association's election with respect to policies, contracts, or annuities covered in whole or in part by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver, rehabilitator, or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other within five (5) days of the completion of the calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association under subparagraph 2. of this paragraph, the receiver, rehabilitator, or liquidator shall remit those amounts to the association as promptly as practicable; and
 4. If the association, within sixty (60) days of the election, pays the premiums due for periods both before and after the coverage date that relate to policies, contracts, or annuities covered by the association in whole or in part, the member insurer shall not be entitled to terminate the reinsurance agreements insofar as the agreements relate to policies, contracts, or annuities covered by the association in whole or in part and shall not be entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association.
- (b) If the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under paragraph (a) of this subsection effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in paragraph (a) of this subsection if:
1. The indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other member insurer agree to the contrary;
 2. The obligations described in subparagraph 2. of paragraph (a) of this subsection no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party member insurer; and
 3. The association has not previously expressly determined in writing that it will not exercise the election referred to in paragraph (a) of this subsection.

- (c) The provisions of this subsection shall supersede the provisions of any state law or of any affected reinsurance agreements that provide for or require any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance agreements with respect to losses or events that occur in periods prior to the coverage date, subject to applicable setoff provisions.
 - (d) Except as otherwise expressly provided in this subsection, nothing in this subsection shall alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. Nothing in this subsection shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. Nothing in this subsection shall give a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.
- (16) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this subtitle in an economical and efficient manner.
 - (17) If the association has arranged or offered to provide the benefits of this subtitle to a covered person under a plan or arrangement that fulfills the association's obligations under this subtitle, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.
 - (18) Venue in a suit against the association under this subtitle shall be in Franklin County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this subtitle.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 5, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 24, sec. 1562, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 537, sec. 5, effective July 15, 1998. -- Amended 1988 Ky. Acts ch. 282, sec. 3, effective July 15, 1988. -- Created 1978 Ky. Acts ch. 282, sec. 8, effective June 17, 1978.

304.42-090 Assessments -- Classification -- Certificate of contribution -- Payment under protest.

- (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight percent (8%) per annum on and after the due date.
- (2) There shall be two (2) classes of assessments:
 - (a) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer;
 - (b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under KRS 304.42-080 with regard to an impaired or insolvent insurer.
- (3)
 - (a) The amount of any Class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.
 - (b) 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 commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.
 - (c) 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 or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became insolvent, or in the case of assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became impaired, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.
 - (d) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this subtitle. Classification of assessments under

subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

- (4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, 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. Once the conditions that caused a deferral have been removed or rectified, the member shall pay all assessments that were deferred under a repayment plan approved by the association.
- (5)
 - (a) Subject to the provisions of paragraph (b) of this subsection, the total of all assessments authorized by the association with respect to a member insurer for each account shall not in any one (1) calendar year exceed two percent (2%) of the member insurer's average annual premiums received in this state on the policies and contracts covered by the account during the three (3) calendar years preceding the year in which the member insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any other account, does not provide in any one (1) year in any other account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this subtitle.
 - (b) If two (2) or more assessments are authorized in one (1) 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 referenced in paragraph (a) of this subsection shall be equal and limited to the higher of the three (3) year average annual premiums for the applicable account as calculated under this section.
 - (c) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.
 - (d) If the maximum assessment for the life insurance account or the annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then, pursuant to paragraph (c) of this subsection, the board shall access the other account for the necessary additional amount, subject to the maximum stated in paragraph (a) of this subsection.
- (6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer

to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, 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 association and for future losses claims.

- (7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this subtitle, to consider the amount reasonably necessary to meet its assessment obligations under this subtitle.
- (8) The association shall issue to each member insurer paying an assessment under this subtitle, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.
- (9)
 - (a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.
 - (b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.
 - (c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal the final action to the commissioner, in accordance with KRS 304.42-110(3).
 - (d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.
 - (e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.
- (10) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply

with a request.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 6, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 24, sec. 1563, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 537, sec. 6, effective July 15, 1998. -- Amended 1988 Ky. Acts ch. 282, sec. 4, effective July 15, 1988. -- Amended 1986 Ky. Acts ch. 437, sec. 32, effective July 15, 1986. -- Created 1978 Ky. Acts ch. 282, sec. 9, effective June 17, 1978.

304.42-100 Plan of operation.

- (1) (a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner;
- (b) If the association fails to submit a suitable plan of operation within one hundred eighty (180) days following June 17, 1978, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this subtitle. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- (2) All member insurers shall comply with the plan of operation.
- (3) The plan of operation shall, in addition to requirements enumerated elsewhere in this subtitle:
 - (a) Establish procedures for handling the assets of the association;
 - (b) Establish the amount and method of reimbursing members of the board of directors under KRS 304.42-070;
 - (c) Establish regular places and times for meetings of the board of directors;
 - (d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;
 - (e) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;
 - (f) Establish any additional procedures for assessments under KRS 304.42-090;
 - (g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- (4) The plan of operation may provide that any or all powers and duties of the association, except those under paragraph (c) of subsection (10) of KRS 304.42-080 and 304.42-090, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this subtitle.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1564, effective July 15, 2010. -- Created 1978 Ky. Acts ch. 282, sec. 10, effective June 17, 1978.

304.42-110 Duties and powers of commissioner.

In addition to the duties and powers enumerated elsewhere in this subtitle:

- (1) The commissioner shall:
 - (a) Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer;
 - (b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties under this subtitle; and
 - (c) In any liquidation or rehabilitation proceeding involving a domestic member insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the commissioner may be appointed conservator.
- (2) The commissioner may suspend or revoke, after notice and hearing conducted in accordance with KRS Chapter 13B, the certificate of authority or license to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. A forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars (\$100) per month.
- (3) Any final action of the board of directors or the association may be appealed to the commissioner by any member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the action being appealed. Any final order of the commissioner shall be subject to judicial review as set forth in Subtitle 2 of this chapter and KRS Chapter 13B.
- (4) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this subtitle.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 7, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 24, sec. 1565, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 537, sec. 7, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 318, sec. 248, effective July 15, 1996. -- Amended 1988 Ky. Acts ch. 282, sec. 5, effective July 15, 1988. -- Created 1978 Ky. Acts ch. 282, sec. 11, effective June 17, 1978.

304.42-120 Detection and prevention of member insurer insolvencies or impairments.

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

- (1) It shall be the duty of the commissioner:
 - (a) To notify the commissioners of all of the other states, territories of the United States and the District of Columbia when he or she takes any of the following actions against a member insurer:
 1. Revocation of license;
 2. Suspension of license;
 3. Makes any formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders, or creditors.

Such notice shall be mailed to all commissioners within thirty (30) days following the action taken or the date on which such action occurs;
 - (b) To report to the board of directors when he or she has taken any of the actions set forth in paragraph (a) of this subsection or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner;
 - (c) To report to the board of directors when he or she has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the member insurer may be an impaired or insolvent insurer; and
 - (d) To furnish to the board of directors the NAIC insurance regulatory information system information developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.
- (2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his or her duties and responsibilities regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in this state.
- (3) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any insurer or health maintenance organization seeking to do business in this state. These reports and recommendations are confidential by law and shall not be considered public records.

- (4) The board of directors may, upon majority vote, notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.
- (5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 8, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 24, sec. 1566, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 537, sec. 8, effective July 15, 1998. -- Amended 1988 Ky. Acts ch. 282, sec. 6, effective July 15, 1988. -- Created 1978 Ky. Acts ch. 282, sec. 12, effective June 17, 1978.

304.42-130 Offset of premium tax liability to state – Surcharge on premiums.

- (1) A member insurer, other than a nonprofit hospital, medical, surgical, dental, or health service corporation, may offset its tax liability to this state imposed against it under KRS 136.320(3) and (4), 136.330, 136.340, or 136.350, whichever may be applicable, against the assessment described in subsection (8) of KRS 304.42-090 to the extent of twenty percent (20%) of the amount of the assessment for each of the five (5) calendar years following the year in which the assessment was paid. If a member insurer should cease doing business, all uncredited assessments may be credited against its tax liability for the year in which it ceases doing business.
- (2) A member insurer that is exempt from taxes referenced in subsection (1) of this section may recoup its assessments by a surcharge on its premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the commissioner. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, the medical loss ratio, or agent commission. If a member insurer collects excess surcharges, the member insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- (3) Any sums acquired by refund, pursuant to KRS 304.42-090(6), from the association which have theretofore been written off by contributing member insurers and offset against taxes as provided in this section, and are not then needed for purposes of this subtitle, shall be paid by the association to the commissioner and by the commissioner deposited with the State Treasurer for credit to the general fund of this state.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 9, effective June 27, 2019. -- Amended 2010 Ky. Acts ch. 24, sec. 1567, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 233, sec. 5, effective July 15, 1998. -- Created 1978 Ky. Acts ch. 282, sec. 13, effective June 17, 1978.

304.42-140 Liquidation, rehabilitation or conservation proceedings.

- (1) Nothing in this subtitle shall be construed to reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.
- (2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under KRS 304.42-080. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, prior to the termination of the impairment or insolvency of the member insurer, or prior to the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under KRS 304.42-150.
- (3) For the purpose of carrying out its obligations under this subtitle, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subsection (8) of KRS 304.42-080. Assets of the impaired or insolvent insurer attributable to covered policies and contracts shall be used to continue all covered policies and contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this subtitle. Assets attributable to covered policies or contracts, as used in this subsection, is that proportion of the assets which the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies or contracts or health benefit plans written by the impaired or insolvent insurer.
- (4) As a creditor of the impaired or insolvent insurer as established in subsection (3) of this section and consistent with KRS 304.33-440, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this subtitle. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.
- (5) (a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, enrollees, certificate holders, contract owners, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the enrollees, certificate holders, contract owners, and policy owners of the continuing or successor member insurer;

- (b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association for funds expended in carrying out its powers and duties under KRS 304.42-080 with respect to the member insurer have been fully recovered by the association.
- (6) (a) If an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to 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 (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b) to (d) of this subsection;
- (b) No distribution 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;
- (c) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions he 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 which would have been received if they had been paid immediately. If two (2) persons are liable with respect to the same distributions, they shall be jointly and severally liable;
- (d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer;
- (e) If any person liable under paragraph (c) of this subsection is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 10, effective June 27, 2019. -- Amended 1998 Ky. Acts ch. 537, sec. 9, effective July 15, 1998. -- Created 1978 Ky. Acts ch. 282, sec. 14, effective June 17, 1978.

Legislative Research Commission Note (modified 10/29/96). Subsection (3) of this statute contains the following text, which appears to be incomplete: "Assets of the impaired or insolvent insurer as required by this subtitle." The provisions of KRS 304.42-010 to 304.42-190 were modeled after the Model Act of the National Association of Insurance Commissioners on Life and Health Guaranty Associations, in which the following language appears after the word "insurer" in the text specified above: "attributable to cover losses should be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer."

304.42-150 Examination of the association.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of its activities during the preceding calendar year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1568, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 537, sec. 10, effective July 15, 1998. -- Created 1978 Ky. Acts ch. 282, sec. 15, effective June 17, 1978.

304.42-160 Tax exemption.

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

Effective: June 17, 1978

History: Created 1978 Ky. Acts ch. 282, sec. 16, effective June 17, 1978.

304.42-170 Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action taken by them in the performance of their powers and duties under this subtitle. Immunity shall extend to the participation in any organization of one (1) or more other state associations of similar purposes and to any such organization and its agents or employees.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1569, effective July 15, 2010. -- Amended 1998 Ky. Acts ch. 537, sec. 11, effective July 15, 1998. -- Created 1978 Ky. Acts ch. 282, sec. 17, effective June 17, 1978.

304.42-180 Court proceedings to be stayed.

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty (60) days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

Effective: June 17, 1978

History: Created 1978 Ky. Acts ch. 282, sec. 18, effective June 17, 1978.

304.42-190 Advertising restrictions.

No person, including a member insurer, agent, affiliate of a member insurer, life settlement provider, or life settlement broker shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement which uses the existence of the Insurance Guaranty Association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by the Kentucky Life and Health Insurance Guaranty Association Act. This section shall not apply to the Kentucky Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

Effective: June 27, 2019

History: Amended 2019 Ky. Acts ch. 70, sec. 11, effective June 27, 2019. -- Amended 2008 Ky. Acts ch. 32, sec. 24, effective July 15, 2008. -- Amended 2000 Ky. Acts ch. 472, sec. 11, effective July 14, 2000. -- Created 1978 Ky. Acts ch. 282, sec. 19, effective June 17, 1978.