LOUISIANA LIFE AND HEALTH INSURANCE

GUARANTY ASSOCIATION ACT

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§2081. Title: construction

This Part shall be known and may be cited as the "Louisiana Life and Health Insurance Guaranty Association Law" and shall be construed to affect the purpose under R.S. 22:2082.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.1 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1.

NOTE: Former R.S. 22:2081 redesignated as R.S. 22:493 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2082. Purpose

A. The purpose of this Part is to protect, subject to certain limitations, the persons listed in R.S. 22:2083(A) against failure in the performance of contractual obligations, under life and health, and annuity policies, plans, or contracts specified in R.S. 22:2083(B), because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

B. To provide this protection, an association of member insurers is hereby created to pay benefits and to continue coverages as limited herein. Members of the association are subject to assessment to provide funds to carry out the purpose of this Part.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.2 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2018, No. 97, §1: Acts 2018, No. 97, §1.

NOTE: Former R.S. 22:2082 redesignated as R.S. 22:494 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2083. Coverages and Limitations

A. This Part shall provide coverage for the policies and contracts specified in Subsection B of this Section:

(1) To any person who, regardless of residence, except for a nonresident certificate holder under a group policy or contract, is the beneficiary, assignee, or payee, including healthcare providers rendering services covered under health insurance policies or certificates, of a person covered under Paragraph (2) of this Subsection.

(2) To any person who is the owner of or certificate holder or enrollee under such a policy or contract, other than a structured settlement annuity, and who is either:

(a) Is a resident; or

(b) Not a resident, but only if all of the following conditions are satisfied:

(i) The member insurer which issued such policy or contract is domiciled in this state.

(ii) The member insurer has never held a license or certificate of authority in the state in which such person resides.

(iii) The state has an association similar to the association created by this Part.

(iv) The person is not eligible for coverage by such association.

(3) For structured settlement annuities specified in Subsection B of this Section, Paragraphs (1) and (2) of this Subsection shall not apply, and this Part shall, except as provided in Paragraphs (4) and (5) of this Subsection, provide coverage to a person who is a payee under a structured settlement annuity, or a beneficiary of a payee if the payee is deceased, if the payee is one of the following:

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

(b) Not a resident, but only under both of the following conditions:

(i) The contract owner of the structured settlement annuity either is a resident or is not a resident and meets both of the following conditions in the case where the contract owner is not a resident:

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

(bb) The state in which the contract owner resides has an association similar to the association created by this Part.

(ii) Neither the payee, or the beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) This Part shall not provide coverage to:

(a) 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.

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

(5) This Part 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 under this Part is provided coverage under the laws of any other state, the person shall not be provided coverage under this Part. 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 state, whether as an owner, payee, enrollee, beneficiary or assignee, this Part shall be construed in conjunction with other state laws to result in coverage by only one association.

B. (1) This Part shall provide coverage to the persons specified in Subsection A of this Section for policies or contracts of direct, non-group life insurance, health insurance including, for purposes of the Part, health maintenance organization subscriber contracts and certificates, or annuities, for certificates under direct group policies and contracts, for supplemental contracts to any of these, and for unallocated annuity contracts, in each case issued by member insurers, except as limited by this Part.

(2) Except as otherwise provided in Paragraph (3) of this Subsection, this Part shall not provide coverage for any of the following:

(a) 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 holder.

(b) Any policy or contract of reinsurance, unless assumption certificates have been issued.

(c) Any portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(i) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this Part, 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 such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this Part, whichever is earlier.

(ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this Part, 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.

(d) Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

(i) A Multiple Employer Welfare Arrangement as defined in 29 U.S.C. Section 1002(40) (the Employee Retirement Income Security Act of 1974) as amended.

(ii) A minimum premium group insurance plan.

(iii) A stop-loss group insurance plan.

(iv) An administrative services only contract.

(e) Any portion of a policy or contract to the extent that it provides dividends, premium refunds, or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract.

(f) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state.

(g) Any unallocated annuity contract except unallocated annuity contracts and defined contribution government plans qualified under Section 403(b) of the United States Internal Revenue Code (26 U.S.C. 403(b)).

(h) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, contract owner, certificate holder or policy owner, including without limitations, any of the following:

(i) Claims based upon marketing materials.
(ii) 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.
(iii) Misrepresentations of or regarding policy or contract benefits.
(iv) Extra-contractual claims.
(v) A claim for penalties or consequential or incidental damages.

(i) A policy or contract providing any hospital, medical, prescription drug or other healthcare benefits pursuant to Part A, Part B, Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly referred to as " Medicare Part A coverage, "Medicare Part B coverage", "Medicare Part C coverage" and "Medicare Part D coverage", of Subchapter XIX of Chapter 7 of Title 42 of the United States Code, commonly referred to as "Medicaid", and any regulations issued pursuant to those parts or subchapters.

(j) A portion 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 or insolvent insurer under this Part, whichever is

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

(k) Structured settlement annuity benefits to which a payee or beneficiary has transferred his rights in a “structures settlement factoring transaction” as defined in 26 U.S.C. 5891 (c)(3)(A), regardless of when the transaction occurred.

(3) The exclusion from coverage provided for in Subparagraph (2)(c) 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.

C. The benefits for which the association shall become liable shall in no event exceed the lesser of the following:

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

(2) With respect to any 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) Five hundred thousand dollars in health insurance benefits.

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

D. However, in no event shall the association be liable to expend more than five hundred thousand dollars in the aggregate with respect to any one individual under Subsection C of this Section.

E. The liability of the association and benefits paid by the association under any valid act of assignment of benefits pursuant to Subsection C of this Section for any claim under a health policy shall be an amount payable under Title XVIII of the Social Security Act, 42 U.S.C.§ 301 et seq. The board of directors of the association shall establish reasonable amounts for any services or supplies covered under a health policy or contract for which an amount has not been determined under the federal Medicare program. A health care provider, defined in R.S. 40:1231.1, shall not bill any person covered by a health policy or contract for which the association has become liable for the amount of any bill in excess of the amount paid by the association.

F. For purposes of this Part, 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.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.3 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1. Acts 2012, No. 271, §1; Acts 2014, No. 374, §1; Acts 2017, No. 13, §1, eff. July 1, 2017; Acts 2018, No. 97, §1.

NOTE: Former R.S. 22:2083 redesignated as R.S. 22:495 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2084. Definitions

As used in this Part:

(1) "Account" means any of the four accounts created by R.S. 22:2085(A).

(2) "Association" means the Louisiana Life and Health Insurance Guaranty Association created by R.S. 22:2085.

(3) "Commissioner" means the commissioner of insurance.

(4) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided by R.S. 22:2083.

(5) "Covered contract" or "covered policy" means any policy or contract within the scope of this Part as set forth in R.S. 22:2083.

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

(7) "Insolvent insurer" means a member insurer which is placed under an order by a court of competent jurisdiction with a finding of insolvency.

(8) "Member insurer" means any insurer or health maintenance organization licensed or which holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided by R.S. 22:2083, 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 shall not include any of the following:

(a) Repealed by Acts 2018, No. 97, §2.

(b) A fraternal benefit society.

(c) A mandatory state pooling plan.

(d) A mutual assessment company or any entity that operates on an assessment basis.

(e) An insurance exchange.

(f) A hospital or medical service organization, whether operated for profit or as nonprofit.

(g) An organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3).

(h) Any entity similar to any of the above.

(9) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(10) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(11) "Premiums" means amounts received on covered policies or contracts, less considerations, deposits, dividends, and experience credits thereon. "Premiums" shall not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided by R.S. 22:2083(B), except that accessible premiums shall not be reduced on account of R.S. 22:2083(B)(2)(c)(ii) relating to interest limitations with respect to any one individual, any one participant, and any one policyholder.

(11.1) “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.

(12) "Resident" means a person 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 a court order that determines a member insurer to be an insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one 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 Part, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(12.1) "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.

(13) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(14) "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.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1994, 3rd Ex. Sess., No. 92, §1; Redesignated from R.S. 22:1395.4 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1; Acts

2012, No. 271, §1; Acts 2014, No. 374, §1; Acts 2018, No. 97, §§1, 2; Acts 2021, No. 19, §1, eff. June 1, 2021.

NOTE: Former R.S. 22:2084 redesignated as R.S. 22:496 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2085. Creation of the Association

A. There is hereby created a nonprofit entity to be known as the Louisiana Life and Health Insurance Guaranty Association whose legal domicile shall be in the parish of East Baton Rouge. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business in this state. The association shall perform its function under the plan of operation established and approved pursuant to R.S. 22:2089 and shall exercise its powers through a board of directors pursuant to R.S. 22:2086. For purposes of administration and assessment, the association shall maintain all of the following accounts:

(1) The life insurance account.

(2) The annuity account excluding unallocated annuity contracts and defined contribution government plans qualified under Section 403(b) of the United States Internal Revenue Code (26 U.S.C. Section 403(b)).

(3) The defined contribution plan account, meaning defined contribution plans qualified under Section 403(b) of the United States Internal Revenue Code.

(4) The health account.

B. 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. The association shall provide any records concerning the operations, budget, and management of the association upon request of the commissioner.

C. (1) Notwithstanding any other provision of law to the contrary, the association is not and may not be deemed a department, unit, agency, instrumentality, commission, or board of the state for any purpose unless specifically set forth herein and shall not be subject to laws governing such departments, units, agencies, instrumentalities, commissions, or boards of the state. All debts, claims, obligations, and liabilities of the association, whenever incurred, shall be the debts, claims, obligations, and liabilities of the association only and not of the state, its agencies, instrumentalities, officers, or employees. The state may not budget for or provide general fund appropriations to the association, and the debts, claims, obligations, and liabilities of the association may not be considered to be a debt of the state or a pledge of its credit. The association shall be subject to the provisions of R.S. 24:513 et seq. regarding audits by the legislative auditor. The form established by the commissioner pursuant to R.S. 22:2064 for the financial report shall determine the association's accounting method and basis of financial reporting for all purposes notwithstanding any other provision to the contrary.

(2) Notwithstanding the provisions of Paragraph (1) of this Subsection, and except as provided in Paragraph (3) of this Subsection, the association shall be subject to the provisions of R.S. 44:1 et seq. and R.S. 42:11 et seq., and may be considered as if it were a public body for the purposes of this Section.

(3) The association may hold an executive session pursuant to R.S. 42:16 for discussion of one or more of the following, and R.S. 44:1 et seq. shall not apply to any documents as enumerated in R.S. 44:1(A)(2) which relate to one or more of the following:

(a) A request by the association or the commissioner for an examination of a member insurer pursuant to R.S. 22:2091.

(b) Reports and recommendations made by the association to the commissioner pursuant to R.S. 22:2093 on any matter relevant to the solvency, impairment, liquidation, rehabilitation, or conservation of any member insurer, until such insolvency has been declared or the member insurer has been placed in liquidation, rehabilitation, or conservation.

(c) Matters protected by attorney-client privilege.

(d) Matters with respect to claims or claim files, except documents contained in those files which are otherwise deemed public records.

(e) Prospective litigation against the association after formal written demand, prospective litigation by the association after referral to counsel for review, or pending litigation by or against the association.

(f) Any other matters now provided for or as may be provided for by the legislature.

(g) Discussion by or documents in the custody or control of any committee or subcommittee of the association, or any member or agent thereof, or the board of directors or any member or agent thereof, if such discussion or documents would otherwise be protected from disclosure by any of the exceptions provided in this Paragraph.

(h) Matters with respect to the abatement or deferral or the request for an abatement or deferral of an assessment pursuant to R.S. 22:2088(D).

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1992, No. 115, §1; Acts 1997, No. 534, §1, eff. July 3, 1997; Redesignated from R.S. 22:1395.5 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2012, No. 271, §1; Acts 2018, No. 97, §1.

NOTE: Former R.S. 22:2085 redesignated as R.S. 22:497 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2086. Board of Directors

A. The board of directors of the association shall consist of one consumer representative appointed by the commissioner subject to Senate confirmation, who shall be a resident of the state of Louisiana, and ten member insurers serving terms as established in the plan of operation. The consumer representative shall not be an officer, director, or employee of an insurance company or engaged in the business of insurance or a health maintenance organization. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner from the following groups or their successors:

(1) One representative of a member insurer which is a domestic commercial insurance company and a member of the Louisiana Insurers' Conference.

(2) Two representatives of member insurers selected from recommendations of the American Council of Life Insurers.

(3) One representative of a member insurer selected from recommendations of America’s Health Insurance Plans.

(4) One representative of a member insurer which is a domestic commercial health insurer.

(5) One representative of a member insurer which is a member of the Life Insurers' Conference.

(6) One representative of a member insurer which is a member of the American Council of Life Insurers Forum 500.

(7) One representative, who represents a member insurer which is a domestic nonprofit mutual insurer engaged exclusively in the business of furnishing hospital service, medical, or surgical benefits.

(8) Two persons, one appointed by the president of the Senate and one appointed by the speaker of the House of Representatives, both of whom shall be residents of the state of Louisiana.

B. 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.

C. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

D. Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors. The members of the board shall otherwise not be compensated by the association for their services.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1994, 3rd Ex. Sess., No. 92, §1; Redesignated from R.S. 22:1395.6 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1. Acts 2012, No. 271, §1; Acts 2018, No. 97, §1.

NOTE: Former R.S. 22:2086 redesignated as R.S. 22:498 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2087. Powers and Duties of the Association

A. If a member insurer is an impaired insurer, the association may, in its discretion, subject to any conditions imposed by the association, take any of the following actions that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(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 such monies, pledges, notes, loans, 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 under Paragraph (1) of this Subsection.

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

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

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

(3) Provide such monies, pledges, notes, loans, guarantees, or other means as are reasonably necessary to discharge such duties.

(4) Provide benefits and coverages in accordance with Subsection C of this Section.

C. With respect to policies and contracts the association shall do all of the following:

(1) Assure payment of benefits, that would have been payable under the 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 the policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies and contracts.

(b) With respect to non-group policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under the policies or one year, but in no event less than

thirty days, from the date on which the association becomes obligated with respect to the policies or contracts.

(2) Make reasonable and diligent efforts to provide all known insureds, enrollees, or annuitants for non-group policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty days prior notice of the termination of the benefits provided.

(3) With respect to non-group policies and contracts covered by the association, make available to each known insured, enrollee or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of Paragraph (4) of this Subsection, 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 to unilaterally alter any provision of the policy, contract, or annuity or had a right to undertake alterations only in premium by class.

(4) (a) In providing the substitute coverage required pursuant to Paragraph (3) of this Subsection, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the commissioner.

(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 the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(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 that it 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.

(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 the prior approval of the commissioner.

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

(8) When proceeding pursuant to this Subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with R.S. 22:2083(B)(2)(c).

D. Repealed by Acts 2014, No. 374, §2.

E. Repealed by Acts 2014, No. 374, §2.

F. Nonpayment of premiums within thirty-one days after the date required by the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under such policy, contract, or coverage under this Part 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 Part.

G. 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. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premiums collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

H. The protection provided by this Part shall not apply if any guaranty 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.

I. In carrying out its duties under Subsections (B) and (C) of this section, the association may, subject to approval by the court:

(1) 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 Part are less than the amounts needed to assure full and prompt performance of this association's duties under this Part, 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.

(2) Impose temporary restraining orders 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.

J. If the association fails to act within a reasonable period as provided in Subsections (B) and (C) of this Section, the commissioner shall have the powers and duties of the association under this Part with respect to impaired or insolvent insurers.

K. The association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

L. The association shall have standing to appear or intervene before any court in this state or state agency with jurisdiction over an impaired or insolvent insurer and concerning which the association shall become obligated under this Part or with jurisdiction over any other person or property against which the association may have benefit through subrogation or otherwise. The 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 any person or property for which the association shall become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation or otherwise.

M. (1) Any person receiving benefits under this Part shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received because of this Part, whether the 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 of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Part upon such person.

(2) 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 Part.

(3) In addition to Paragraphs (1) and (2) of this Subsection, the association shall have all rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such policy or contracts.

(4) If the provisions of this Subsection are determined to be 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 or claim that is attributable to the policies, contracts, or portion thereof, covered by the association.

(5) 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 Paragraph (4) of this

Subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or the portion thereof, covered by the association.

N. The association may do any of the following:

(1) Enter into any contracts necessary or proper to implement the provisions and purposes of this Part.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments pursuant to R.S. 22:2088 and to settle claims or potential claims against it.

(3) Borrow money to affect the purposes of this Part. 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.

(4) Employ or retain any persons necessary to handle the financial and legal transactions of the association, and to perform other functions necessary or proper in accordance with this Part.

(5) Take any legal action necessary to avoid payment or recover payment of improper claims.

(6) Exercise, for the purposes of this Part 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 annuity contracts other than those issued to perform its obligations under this Part.

(7) 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 pursuant to this Part.

O. The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

P. (1) Venue in a suit against the association arising under this Part shall be in the Nineteenth Judicial District.

(2) The association shall not be required to furnish an appeal bond that relates to a cause of action arising under this Part.

Q. In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under this Section, the association 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 that meets the following requirements:

(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 one of the following:

(a) A fixed interest rate.

(b) Payment of dividends with minimum guarantees.

(c) 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.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 2012, No. 271, §1; Acts 2014, No. 374, §§1,2; Acts 2018, No. 97, §1.

§2088. Assessments

A. 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 for the administration of the provisions of this Part. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten percent per annum on and after the due date.

B. There shall be two assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of R.S. 22:2091. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer and their administration thereof.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association pursuant to R.S. 22:2087 with regard to an impaired or an insolvent insurer.

C. (1) The amount of any Class A assessment shall be determined by the board. 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 and established in the plan of operation.

(2) 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 of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

(3) 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 most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(4) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be commenced by the board of directors until necessary to implement the purposes of this Part. Classification of assessments pursuant to Subsection B of this Section and computation of assessments pursuant to this Subsection shall be made with a reasonable degree of accuracy.

D. The association may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the event an assessment against an 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 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 insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

E. (1) (a) The total of all assessments upon an insurer for each account shall not in any one calendar year exceed two percent of such average premiums received of the insurers 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 or insolvent insurer.

(b) With respect to member insurers that become impaired or insolvent in different calendar years, if two or more assessments are authorized in one calendar year, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in Subparagraph (a) of this Paragraph shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated pursuant to this Section.

(c) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the obligations of the association, the necessary additional funds shall be assessed as permitted by this Part

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

F. 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 that 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.

G. 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 Part, to consider the amount reasonably necessary to meet its assessment obligations under this Part.

H. The association shall issue to each member insurer paying an assessment under this Part, other than Class A assessments, a certificate of contribution for Class B assessments, 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 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.

I. (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the 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.

(2) Within sixty 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.

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

(4) 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.

(5) 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.

J. The association may request information of member insurers in order to aid in the exercise of its powers under this Section and member insurers shall promptly comply with a request.

Acts 1991, No. 998,§ 1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.8 by Acts 2008, No. 415, §1, eff. Jan 1, 2009; Acts 2009, No. 258, §1; Acts 2012, No. 271, §1; Acts 2018, No. 97, §1.

§2089. Plan of Operation

A. (1) 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 either upon the commissioner's written approval or thirty days after submission if he has not disapproved it.

(2) If at any time 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 Part. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

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

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this Part:

(1) Establish procedures for handling the assets and liabilities of the association.

(2) Establish the amount and method of reimbursing members of the board of directors under R.S. 22:2086.

(3) Establish regular places and times for meetings, including telephone conference calls, of the board of directors.

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(5) Establish the procedures whereby selections for the board of directors shall be made and submitted to the commissioner.

(6) Establish any additional procedures for assessments pursuant to R.S. 22:2088.

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(8) Establish procedures by which a director may be removed for cause, including, but not limited to, the case where the director of a member insurer becomes impaired or insolvent.

(9) Require the board of directors to establish policy and procedures for addressing conflicts of interest.

D. The plan of operation may provide that any or all powers and duties of the association, except those under R.S. 22:2087(M)(3) are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Any corporation, association, or organization which undertakes this function 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 prior 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 Part.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.9 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1; Acts 2012, No. 271, §1.

§2090. Powers and Duties of the Commissioner

A. In addition to the duties and powers enumerated elsewhere in this Part, and in other provisions of law, the commissioner shall do all of the following:

(1) Upon request of the board of directors, and notwithstanding any other law to the contrary, provide the association with a statement of the premiums, in this and any other appropriate states, for each member insurer.

(2) 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. The notice to the impaired insurer shall constitute notice to its shareholders, if applicable. The failure of the impaired insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this Part.

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

B. The commissioner may suspend or revoke, after compliance with R.S. 49:961, the certificate of authority to transact business in this state of any member insurer who fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may also levy a fine on any member insurer who fails to pay an assessment when due. The fine shall not exceed five percent of the unpaid assessment per month, but no fine shall be less than one hundred dollars per month.

C. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the final action being appealed. If a member insurer is appealing an assessment, the amount assessed shall be paid to the association and credited to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount if paid in error or excess, shall be returned to the member insurer without interest. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

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

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.10 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1; Acts 2009, No. 317, §1; Acts 2018, No. 97, §1.

§2091. Prevention of Insolvencies

A. To aid in the detection and prevention of member insurer insolvencies or impairments, it shall be the duty of the commissioner:

(1) (a) To notify the commissioner of insurance, or other appropriate official, of all the other states, territories of the United States, and the District of Columbia when he takes any of the following actions against a member insurer:

(i) Revokes any license.

(ii) Suspends any license.

(iii) 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 policyholders, contract owners, certificate holders or creditors.

(b) The notice shall be mailed to all such commissioners or other appropriate officials within thirty days following the action taken or the date on which such action occurs.

(2) To report to the board of directors when he has taken any of the actions set forth in Paragraph (1) 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 or other appropriate official.

(3) To report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of a member insurer that the member insurer may be an impaired or insolvent insurer.

(4) To furnish to the board of directors of the National Association of Insurance Commissioners (NAIC), Insurance Regulatory Information System (IRIS), ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The board may then use the information contained therein in carrying out its duties and responsibilities. The report and the information contained therein shall be kept confidential by the board of directors.

B. The commissioner may seek the advice and recommendation of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member

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

C. 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 transact insurance business in this state. Such reports and recommendations shall not be considered public records.

D. It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

E. Repealed by Acts 2018, No. 97, §2.

(2) The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

F. The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

G. Repealed by Acts 2018, No. 97, §2.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.11 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2012, No. 271, §1; Acts 2018, No. 97, §§1,2.

§2092. Offsets for Assessments Paid

A. An insurer may offset against any premium tax liability to the state an assessment not greater than twenty percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid in full. In the event a member insurer should voluntarily cease doing business in this state, all uncredited assessments may be credited against any premium, franchise, or income tax due for the year it ceases doing business.

B. The amount of the assessment payable shall be reduced from the amount otherwise fixed in this Part if the insurer shall file a sworn statement with the annual report required by R.S. 22:135 through 235 as of December thirty-first for the reporting period that at least the following amounts of the total admitted assets of the insurer, less assets in an amount equal to the reserves on its policies issued in foreign countries in which it is authorized to do business and which countries require an investment therein as a condition of doing business, are invested and maintained in qualifying Louisiana investments as defined in R.S. 22:832(C). If one-sixth of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be sixty-six and two-thirds percent of the amount otherwise assessed. If at least one-fifth of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be seventy-five percent of the amount otherwise assessed. If at least one-fourth of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be eighty-five percent of the amount otherwise assessed.

If at least one-third of the total admitted assets of the insurer are in qualifying Louisiana investments, then the offset shall be ninety-five percent of the amount otherwise assessed.

C. An insurer may transfer any offset as described in this Section with the prior approval of the commissioner to an affiliated insurer. For the purposes of this Section:

(1) "Affiliated insurer" means an insurance company licensed or holding a certificate of authority to do business in this state which controls, is controlled by, or is under common control with, another insurer.

(2) "Control" means holding, directly or indirectly, the ownership of, or power to vote, at least eighty percent of the voting stock of another member insurer.

D. Any sums which are acquired by refund, from the association by insurers, and which have theretofore been offset against premium, franchise and income taxes as provided in Subsection (A) of this Section, shall be paid by the insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.12 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1; Acts 2012, No. 271, §1.

§2093. Miscellaneous Provisions

A. Nothing in this Part shall be construed to reduce or offset the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating a plan with assessment liability.

B. Records shall be maintained of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this Subsection shall limit the duty of the association to render a report of its activities pursuant to R.S. 22:2094.

C. (1) For the purpose of carrying out its obligations under this Part, 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 R.S. 22:2087(M). The assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Part. The assets attributable to covered policies, are that proportion of the assets which the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(2) As a creditor of the impaired or insolvent insurer as established in Paragraph (1) of this Subsection and consistent with R.S. 22:2034, 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 Part. If the liquidator has not, within one hundred and twenty days of a final determination of insolvency of a member by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guarantee 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.

D. (1) 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, contract owners, enrollees, and shareholders of the insolvent insurer, 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 policy owners, contract owners, certificate holders, and enrollees of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties with respect to the member insurer have been fully recovered by the association.

E. (1) 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 years preceding the petition for liquidation or rehabilitation subject to the limitations of Paragraphs (2) and (4) of this Subsection.

(2) No such 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.

(3) 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 received. Any person who was an affiliate that controlled, as defined in R.S. 22:2092(C)(2), the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be solidarily liable.

(4) 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.

(5) If any person liable under Paragraph (3) of this Subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be solidarily liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.13 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1; Acts 2012, No. 271, §1; Acts 2018, No. 97, §1.

§2094. Examination of the Association; Annual Report

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than one hundred twenty days after the end of the fiscal year of the association, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.14 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2095. 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 immovable property.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.15 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2096. 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 his representatives, for any action or omission by them in the performance of their powers and duties under this Part. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.16 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§2097. Stay of Proceeding; Reopening of Default Judgments

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred eighty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on 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 entered such judgment and shall be permitted to defend against such suit on the merits.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.17 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1.

§2098. Prohibited Advertisement of Louisiana Life and Health Insurance Guaranty Association Law in Insurance Sales; Notice to Policyholders

A. No person, including a member insurer, agent, or affiliate of a member insurer 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, written or oral, which uses the existence of the Life and Health 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 Louisiana Life and Health Insurance Guaranty Association Law. This Section shall not apply to the Louisiana Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or covered by a health maintenance organization.

B. Within one hundred eighty days of September 30, 1991, the association shall prepare a summary document describing the general purposes and current limitations of the Part and complying with R.S. 22:2092(C). This document shall be submitted to the commissioner for approval. Sixty days after receiving approval, no member insurer shall deliver a policy or contract described in R.S. 22:2083(B)(1) to a policy owner, contract owner, certificate holder, or enrollee unless the document is delivered to the policy owner, contract owner, certificate holder, or enrollee prior to or at the time of delivery of the policy or contract except if Subsection (D) of this Section applies. The document shall also be available upon request by a policyholder. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the policy owner, contract owner, certificate holder, or enrollee would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to this Part may require. Failure to receive this document shall not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this Part.

C. The document prepared pursuant to Subsection (B) of this Section shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall do all of the following:

(1) State the name and address of the association and the insurance department.

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

(3) State that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance.

(4) Emphasize that the policy or contract holder should not rely on coverage under the association when selecting an insurer.

(5) Provide other information as directed by the commissioner.

D. No insurer or agent may deliver a policy or contract described in R.S. 22:2083(B)(1) and excluded by R.S. 22:2083(B)(2) from coverage under this Part unless the insurer or agent, prior to or at the time of delivery gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall by rule specify the form and content of the notice.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Acts 1994, 3rd Ex. Sess., No. 92, §1; Redesignated from R.S. 22:1395.18 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2009, No. 258, §1. Acts 2012, No. 271, §1; Acts 2014, No. 374, §1; Acts 2018, No. 97, §1.

§2099. Prospective Application

This Part does not apply to any member insurer meeting either of the following criteria:

(1) Any insurer, other than a health maintenance organization described in 5 Paragraph (2) of this Subsection, or its subsidiary, or an insurance holding company system or its directly or indirectly related agent, affiliate, or other entity that is insolvent, impaired, or unable to fulfill its contractual obligations before September 30, 1991.

(2) Any health maintenance organization that is insolvent, impaired, or unable to fulfill its contractual obligations before August 1, 2018.

B. The provisions of this Part effective on September 30, 1991, and subsequent amendments thereto apply prospectively from their effective dates and govern liability for assessments, offsets, refunds, and any other matters relating to all member insurers not identified in Subsection A of this Section.

Section 2. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

Acts 1991, No. 998, §1, eff. Sept. 30, 1991; Redesignated from R.S. 22:1395.19 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009; Acts 2018, No. 97, §1; Acts 2021, No. 19, §1, eff. June 1, 2021.