TO THE HOUSE OF REPRESENTATIVES:

The Committee on Commerce and Economic Development to which was referred Senate Bill No. 95 entitled "An act relating to banking and insurance" respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 8 V.S.A. § 6011(b) is amended to read:

(b) Any captive insurance company may take credit for the reinsurance of risks or portions of risks ceded to reinsurers complying with the provisions of subsections 3634a(a) through ~~(f)~~(e) of this title. Prior approval of the Commissioner shall be required for ceding or taking credit for the reinsurance of risks or portions of risks ceded to reinsurers not complying with subsections 3634a(a) through ~~(f)~~(e) of this title, except for business written by an alien captive insurance company outside the United States.

Sec. 2. 8 V.S.A. § 4728(c)(7) is amended to read:

(7) "Licensee" means a person licensed, authorized to operate, or registered or required to be licensed, authorized, or registered pursuant to the insurance laws of this State, but shall not include:

(A) a captive insurance company;

(B) a purchasing group or risk retention group chartered; or

(C) a licensee domiciled in a jurisdiction other than this State ~~or a person~~ that is acting as an assuming insurer for a licensee domiciled in this State.

Sec. 3. 8 V.S.A. § 2103(b)(3)(A) is amended to read:

(A) return to the applicant ~~any amounts paid for the applicable bond requirement and~~ the bond, if any, and any amounts paid for the applicable license fee; and

Sec. 4. 8 V.S.A. § 2759a(b)(2)(A) is amended to read:

(A) The notice of cancellation shall contain the following information and statements, printed in not less than ~~ten point~~ ten-point boldface type:

NOTICE OF CANCELLATION

(enter date of transaction)

.....

(date)

You may cancel this transaction, without any penalty or obligation, within three business days from the above date.

If you cancel, any payments made by you under the contract will be returned within ~~ten~~ 10 business days following our receipt of your cancellation notice.

To cancel the debt adjustment contract, ~~mail or deliver~~ return a signed and dated copy of this cancellation notice or any other written notice ~~or send a telegram~~ using first-class mail or e-mail, to ..... at

(name of licensee)

.....

(address of licensee's place of business)

(e-mail address of licensee)

not later than midnight of .....

(date)

I hereby cancel this transaction.

.....

(date)

.....

(debtor's signature)

Sec. 5. 9 V.S.A. § 43 is amended to read:

§ 43. DEPOSIT REQUIREMENT PROHIBITED; EXCEPTION

A lender shall not, as a condition to granting or extending a loan, require a borrower to keep or place any sum on deposit with the lender or nominee of the lender, except for deposit arrangements directly related to secured credit cards in a manner consistent with rules adopted by the Commissioner, rules that shall include disclosure requirements, and specific types of alternative

mortgages approved by the Commissioner as provided in 8 V.S.A. § 1256. Any deposit arrangement permitted under this section shall not result in an effective interest rate that exceeds legal rates established in 9 V.S.A. § 41a.

Sec. 6. 8 V.S.A. § 4688(e) is amended to read:

(e) Filings open to inspection. All rates, supplementary rate information, and any nonproprietary supporting information for risks filed under this chapter shall, as soon as filed or after approval for those matters subject to prefiling, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge in the manner and amount prescribed by the Commissioner.

Sec. 7. 8 V.S.A. § 8084a is amended to read:

§ 8084a. REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS

(a) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this subsection to the applicant not later than at the time of delivery of the policy or certificate:

(1) ~~a~~ A statement that the policy may be subject to rate increases in the future~~;~~.

(2) ~~an~~ An explanation of potential future premium rate or rate schedule revisions and the policyholder's or certificate holder's option in the event of a ~~premium rate~~ revision~~;~~.

(3) ~~the~~ The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase~~;~~.

(4) ~~a~~ A general explanation for applying premium rate or rate schedule adjustments that shall include:

(A) a description of when premium rate or rate schedule adjustments will be effective; and

(B) the right to a revised premium rate or rate schedule as provided in subdivision (2) of this subsection (a) if the premium rate or rate schedule is changed~~; and~~.

(5) ~~information~~ Information regarding each premium rate or rate schedule increase on this policy form or similar policy forms over the past 10 years for this State or any other state that, at a minimum, identifies:

(A) ~~the~~ The policy forms for which premium rates or rate schedules have been increased~~;~~.

(B) ~~the~~ The calendar years during which the form was available for purchase~~; and~~.

(C) ~~the~~ The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

* * *

(c) The insurer ~~may~~ shall, in a form and in a fair manner approved by the Commissioner, provide explanatory information related to ~~the~~ premium rate and rate schedule increases covered by this section.

(d) An applicant shall, at the time of application, unless the method of application does not allow for acknowledgment at that time, in such a case, not later than at the time of delivery of the policy or certificate, sign an acknowledgment that the insurer made the ~~disclosure~~ disclosures required under subdivisions (a)(1) and (5) of this section.

(e) An insurer shall provide notice of an upcoming premium rate or rate schedule increase to all policyholders or certificate holders, if applicable, at least ~~45~~ 90 days prior to the implementation of the premium rate or rate schedule increase by the insurer. The notice shall include the information required by subsection (a) of this section when the rate increase is implemented, as well as the explanatory information required by subsection (c) of this section that is specific to the upcoming premium rate or rate schedule increase.

Sec. 7a. 8 V.S.A. § 23(a) is amended to read:

(a) This section shall apply to all persons licensed, authorized, or registered, or required to be licensed, authorized, or registered, under this title or under 9 V.S.A. chapter 150.

Sec. 8. REPEAL

8 V.S.A., chapter 112, subchapter 1 (Life and Health Insurance Companies) and subchapter 2 (Health Maintenance Organization Guaranty Association) are repealed.

Sec. 9. 8 V.S.A. chapter 112, §§ 4171–4190 are added to read:

§ 4171. SHORT TITLE

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

§ 4172. PURPOSE

The purpose of this chapter is to protect, subject to certain limitations, the persons specified in subsection 4173(a) of this chapter, against failure in the performance of contractual obligations under life, health, and annuity policies, plans, and contracts specified in subsection 4173(b) of this chapter, due to the impairment or insolvency of the member insurer that issued such policies, plans, or contracts. To provide this protection:

(1) an association of member insurers is created to enable the guaranty of payment of benefits and of continuation of coverages;

(2) members of the Association are subject to assessment to provide funds to carry out the purpose of this chapter; and

(3) the Association is authorized to assist the Commissioner, in the prescribed manner, in the detection and prevention of insurer impairment or insolvency.

§ 4173. SCOPE

(a) This chapter shall provide coverage for a policy or contract specified in subsection (b) of this section to a person who:

(1) regardless of where the person resides, except for nonresident certificate holders under group policies or contracts, is the beneficiary, assignee, or payee, including a health care provider who renders services covered under a health insurance policy or certificate, of a person covered under subdivision (2) of this subsection; or

(2) is an owner of or certificate holder or enrollee under such policy or contract, other than an unallocated annuity contract or structured settlement annuity, and in each case who:

(A) is a Vermont resident; or

(B) is not a Vermont resident, provided all of the following conditions are met:

(i) the member insurer that issued the policy or contract is domiciled in Vermont;

(ii) the state in which the person resides has an association similar to the Association created by this chapter; and

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

(3) For an unallocated annuity contract specified in subsection (b) of this section, subdivisions (1) and (2) of this subsection shall not apply and this chapter shall, except as provided in subdivisions (5) and (6) of this subsection, provide coverage to a person who is the owner of an unallocated annuity contract if the contract is issued to or in connection with:

(A) a specific benefit plan whose plan sponsor has its principal place of business in Vermont; or

(B) a government lottery, if the owner is a resident of Vermont.

(4) For a structured settlement annuity specified in subsection (b) of this section, subdivisions (1) and (2) of this subsection shall not apply, and this chapter shall, except as provided in subdivisions (5) and (6) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or a beneficiary of such deceased payee, provided that the payee:

(A) is a Vermont resident, regardless of where the contract owner resides; or

(B) is not a Vermont resident, provided that both of the following conditions are met:

(i)(I) the contract owner of the structured settlement annuity is a Vermont resident; or

(II) the contract owner of the structured settlement annuity is not a Vermont resident, provided:

(aa) the insurer that issued the structured settlement annuity is domiciled in Vermont; and

(bb) the state in which the contract owner resides has an association similar to the Association created by this chapter; and

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

(5) This chapter shall not provide coverage to a person who:

(A) is a payee or beneficiary of a contract owner who is a Vermont resident, if the payee or beneficiary is afforded any coverage by the association of another state;

(B) is covered under subdivision (3) of this subsection, if any coverage is provided by the association of another state to the person; or

(C) acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A),

regardless of whether the transaction occurred before or after such section became effective.

(6) This chapter is intended to provide coverage to a person who is a Vermont resident and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this subdivision 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 chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(b)(1) This chapter shall provide coverage to a person specified in subsection (a) of this section for a policy or contract of direct, nongroup life insurance, health insurance, which for purposes of this chapter includes health maintenance organization subscriber contracts and certificates, an annuity, or a certificate under a direct group policy or contract, and supplemental policies or contracts to any of these, and for an unallocated annuity contract, in each case, issued by a member insurer, except as limited by this chapter. An annuity contract or certificate under a group annuity contract includes a guaranteed investment contract, guaranteed interest contract, guaranteed accumulation

contract, deposit administration contract, unallocated funding agreement, allocated funding agreement, structured settlement annuity, annuity issued to or in connection with a government lottery, and any immediate or deferred annuity contract.

(2) Except as otherwise provided in subdivision (3) of this subsection, this chapter shall not provide coverage for:

(A) a 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) a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(C) a 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 chapter, whichever is earlier, exceeds a 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 chapter, whichever is earlier; and

(ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, 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) a portion of a policy or contract issued to a plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

(i) a Multiple Employer Welfare Arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(ii) a minimum premium group insurance plan;

(iii) a stop-loss group insurance plan; or

(iv) an administrative services only contract;

(E) a portion of a policy or contract to the extent that it provides dividends or experience rating credits, voting rights, 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) a policy or contract issued in Vermont 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 Vermont;

(G) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(H) a portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan, or a government lottery;

(I) a portion of a policy or contract to the extent that the assessments required by section 4179 of this chapter with respect to the policy or contract are preempted by federal or State law;

(J) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including:

(i) a claim based on marketing materials;

(ii) a claim based on a side letter, rider, or other document issued by the member insurer without meeting applicable policy or contract form-filing or approval requirements;

(iii) a misrepresentation of or regarding the benefits of a policy or contract;

(iv) an extra-contractual claim; or

(v) a claim for penalties or consequential or incidental damages;

(K) 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, that in each case is not an affiliate of a member insurer;

(L) any 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 that has 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 chapter, 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 subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or

changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(M) any policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Medicare Part C, 42 U.S.C. §§ 1395w-21 to 1395w-29, or Medicare Part D, 42 U.S.C. §§ 1395w-101 to 1395w-154, or Subchapter XIX, Chapter 7 of Title 42 of the U.S.C., commonly known as Medicaid, or any regulations issued pursuant to those sections, or

(N) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(3) The exclusion from coverage referenced in subdivision (2)(C) of this subsection shall not apply to any portion of a contract, including a rider, that provides long-term care or any other health benefits.

(c) The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

(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; or

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

(i) $300,000.00 in life insurance death benefits, but not more than $100,000.00 in net cash surrender and net cash withdrawal values for life insurance;

(ii) for health insurance benefits:

(I) $100,000.00 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(II) $300,000.00 for disability income insurance, and $300,000.00 for long-term care insurance;

(III) $500,000.00 for health benefit plans;

(iii) $250,000.00 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(B) with respect to each individual participating in a governmental retirement benefit plan established under section 401, 403(b), or 457 of the U.S. Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $250,000.00 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(C) with respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $250,000.00 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(D) however, in no event shall the Association be obligated to cover more than:

(i) an aggregate of $300,000.00 in benefits with respect to any one life under subdivisions (2)(A)–(C) of this subsection (c) except with respect to benefits for health benefit plans under subdivision (2)(A)(ii) of this subsection (c), in which case the aggregate liability of the Association shall not exceed $500,000.00 with respect to any one individual; or

(ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000.00 in benefits, regardless of the number of policies and contracts held by the owner;

(E) with respect to either one contract owner provided coverage under subdivision (a)(3)(B) of this section, or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subdivision (2)(B) of this subsection (c), $5,000,000.00 in benefits, irrespective of the number of contracts with respect to the contract owner or

plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in Vermont and in no event shall the Association be obligated to cover more than $5,000,000.00 in benefits with respect to all these unallocated contracts.

(F) The limitations set forth in this subsection (c) 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 chapter may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

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

(d) In performing its obligations to provide coverage under section 4178 of this chapter, the Association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, or 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.

§ 4174. CONSTRUCTION

This chapter shall be liberally construed to effect the purpose under section 4172 of this chapter, which shall constitute an aid and guide to interpretation.

§ 4175. DEFINITIONS

As used in this chapter:

(1) "Account" means either of the two accounts created under section 4176 of this chapter.

(2) "Affiliate" means affiliate as defined in section 3681 of this title.

(3) "Association" means the Vermont Life and Health Insurance Guaranty Association created under section 4176 of this chapter.

(4) "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 specified amount. An assessment is authorized when the resolution is passed.

(5) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(6) "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.

(7) "Commissioner" means the Commissioner of Financial Regulation.

(8) "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 under section 4173 of this chapter.

(9) "Covered contract" or "covered policy" means a policy or contract, or portion of a policy or contract, for which coverage is provided under section 4173 of this chapter.

(10) "Extra-contractual claims" includes, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

(11) "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract, or any other similar health contract. "Health benefit plan" does not include:

(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 types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(12) "Impaired insurer" means a member insurer that, after the effective date of this chapter, is not an insolvent insurer and who is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(13) "Insolvent insurer" means a member insurer that, after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(14) "Member insurer" means any insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this State any kind of insurance or health maintenance organization business for which coverage is provided under section 4173 of this chapter and includes an

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 hospital or medical service organization, whether for-profit or nonprofit;

(B) a fraternal benefit society;

(C) a mandatory State pooling plan;

(D) a mutual assessment company or other person that operates on an assessment basis;

(E) an insurance exchange;

(F) an organization that has a certificate or license limited to the issuance of charitable gift annuities under section 3718a of this title; or

(G) an entity similar to any of the above.

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

(16) "Owner" of a policy or contract and "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.

(17) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

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

(19) "Premiums" mean 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. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of any policies or contracts for which coverage

is not provided under subsection 4173(b) of this chapter except that assessable premium shall not be reduced on account of subdivision 4173(b)(2)(C) of this chapter, relating to interest limitations, and of subdivision 4173(c)(2) of this chapter, relating to limitations with respect to one individual, one participant, and one policy or contract owner. "Premiums" shall not include:

(A) premiums in excess of $5,000,000.00 on an unallocated annuity contract not issued under a governmental retirement benefit plan, or its trustee, established under 26 U.S.C. § 401, 403(b), or 457 of the U.S. Internal Revenue Code; or

(B) with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of $5,000,000.00 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(20)(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 that function, determined by the Association in its reasonable judgment by considering the following factors:

(i) the state in which the primary executive and administrative headquarters of the entity is located;

(ii) the state in which the principal office of the chief executive officer of the entity is located;

(iii) the state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) 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;

(v) the state from which the management of the overall operations of the entity is directed; and

(vi) 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;

(vii) however, in the case of a plan sponsor, if more than 50 percent 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 subdivision (18)(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 in question.

(21) "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.

(22) "Resident" means any person to whom a contractual obligation is owed and who resides in Vermont 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, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person shall be that state where it has its principal place of business. Citizens of the United States who 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 chapter shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

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

(24) "State" means a state, the District of Columbia, Puerto Rico, and a U. S. possession, territory, or protectorate.

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

(26) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

§ 4176. CREATION OF THE ASSOCIATION

(a) There is created a nonprofit legal entity to be known as the Vermont Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance or health maintenance organization business in Vermont. The Association shall perform its functions under the plan of operation established and approved under section 4180 of this chapter and shall exercise its powers through a board of directors established under section 4177 of this

chapter. For purposes of administration and assessment, the Association shall maintain two accounts:

(1) The life insurance and annuity account that includes the following subaccounts;

(A) life insurance account;

(B) annuity account, which shall include annuity contracts owned by a governmental retirement plan, or its trustee, established under section 401, 403(b), or 457 of the U.S. Internal Revenue Code, but shall otherwise exclude unallocated annuities; and

(C) unallocated annuity account, which shall exclude contracts owned by a governmental retirement plan, or its trustee, established under section 401, 403(b), or 457 of the U.S. Internal Revenue Code.

(2) 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. Meetings and records of the Association may be opened to the public upon majority vote of the Board of Directors of the Association.

§ 4177. BOARD OF DIRECTORS

(a) The Board of Directors of the Association shall consist of not less than seven nor more than 11 member insurers serving terms as established in the

plan of operation. Members of the Board shall be selected by member insurers subject to the approval of the Commissioner. A vacancy on the Board shall be filled for the remaining period of the term by a majority vote of the remaining board members, for member insurers subject to the approval of the Commissioner. To select the initial Board of Directors, and initially organize the Association, the Commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer shall be entitled to one vote in person or by proxy. If the Board of Directors is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial insurer members. At least one of the directors shall be a person who is an officer, director, or employee of an insurance company incorporated under the laws of this State; provided, however, this provision shall not apply in the event there is no member insurer incorporated under the laws of this State.

(b) In approving selections or in appointing members to the Board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) 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.

§ 4178. POWERS AND DUTIES OF THE ASSOCIATION

(a) 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:

(1) guarantee, assume, or reissue, reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(2) provide such monies, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision (1) of this subsection and ensure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection.

(b) If a member insurer is an insolvent insurer, the Association, in its discretion, shall either:

(1)(A)(i) guarantee, assume, or reissue, reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or

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

(B) provide monies, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the Association's duties; or

(2) provide benefits and coverages in accordance with the following provisions:

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

(i) with respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the Association becomes obligated with respect to the policies and contracts;

(ii) with respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days, from the date on which the Association becomes obligated with respect to the policies or contracts.

(B) 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, 30 days' notice of the termination, pursuant to subdivision (2)(A) of this subsection (b), of the benefits provided.

(C) With respect to nongroup policies and contracts covered by the Association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual

formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (2)(D) of this subsection (b) 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.

(D)(i) In providing the substitute coverage required under subdivision (2)(C) of this subsection (b), the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract, subject to the prior approval of the Commissioner.

(ii) 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.

(iii) The Association may reinsure any alternative or reissued policy or contract.

(E)(i) 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.

(ii) Alternative policies or contracts shall contain at least the minimum statutory provisions required in Vermont 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. The premium shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(iii) 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.

(F) 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 set by the Association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the Commissioner.

(G) 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 or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the Association.

(H) When proceeding under this subdivision (b)(2) of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall ensure the payment or crediting of a rate of interest consistent with subdivision 4173(b)(2)(C) of this chapter.

(c) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy, contract, or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with the provisions of this chapter.

(d) 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 premium collected by the

Association. The Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) The protection provided by this chapter shall not apply where any guaranty protection is provided to residents of Vermont by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

(f) In carrying out its duties under subsection (b) of this section, the Association may:

(1) Subject to approval by a court in this State, impose permanent policy or contract liens, in connection with a guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts that can be assessed under this chapter are less than the amounts needed to ensure full and prompt performance of the Association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens to be in the public interest.

(2) Subject to the 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.

(g) A deposit in Vermont, held pursuant to 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 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 shall remit to the domiciliary receiver the amount so paid to the Association less the amount retained pursuant to this subsection. Any amount so paid to the Association and retained by it shall be treated as a

distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(h) If the Association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (b) of this section, the Commissioner shall have the powers and duties of the Association under this chapter with respect to the insolvent insurer.

(i) The Association may render assistance and advice to the Commissioner, upon the Commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(j) The Association shall have standing to appear or intervene before any court or agency in Vermont with jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this chapter or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association, including 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.

(k)(1) Any person receiving benefits under this chapter 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 of the benefits received because of this chapter, 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 to it 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 rights or benefits conferred by this chapter 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 chapter.

(3) In addition to subdivisions (1) and (2) 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 the policy or contracts, including, without limitation, in

the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the U.S. Internal Revenue Code.

(4) If the preceding subdivisions 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 or 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 the preceding subdivisions of this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the Association.

(l) In addition to the rights and powers elsewhere in this chapter, the Association may:

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

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 4179 of this chapter and to settle claims or potential claims against it;

(3) borrow money to effect the purposes of this chapter; and 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 such persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this chapter;

(5) take such legal action as may be necessary or appropriate to avoid payment or recover payment of improper claims;

(6) exercise, for the purposes of this chapter and to the extent approved by the Commissioner, the powers of a domestic life insurer, health insurer, or health maintenance organization, but in no event may the Association issue policies or contracts other than those issued to perform its obligations under this chapter;

(7) organize itself as a corporation or in other legal form permitted by Vermont law;

(8) request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request;

(9) unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter; and

(10) take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(m) 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.

(n)(1)(A) At any time within 180 days after the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or by the National Organization of Life and Health

Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(B) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the Association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings:

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

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

(C) Subdivisions (i)–(iv) of this subdivision (1)(C) shall apply to reinsurance contracts assumed by the Association under subdivision (1)(A) of this subsection (n):

(i) The Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in

each case that 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 and shall provide notice and an accounting of these charges to the liquidator.

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

(I) the amount received by the Association; and

(II) the excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy, contracts, or annuity, less the retention of the insurer applicable to the loss or event.

(iii) Within 30 days following the Association's election (the election date), the Association and each reinsurer under contracts assumed by

the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date 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 or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association pursuant to subdivision (1)(C)(ii) of this subsection (n), the receiver shall remit the same to the Association as promptly as practicable.

(iv) If the Association or receiver, on the Association's behalf, within 60 days following the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay

premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

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

(A)(i) neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under subdivision (1) of this subsection (n), whether for periods prior to or after the date of the order of liquidation; and

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

(B) provided that once the Association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by subdivision (1) of this subsection (n).

(3) If the Association does not elect to assume a reinsurance contract by the election date pursuant to subdivision (1) of this subsection (n), the Association shall have no rights or obligations, in each case for periods both

before and after the date of the order of liquidation, with respect to the reinsurance contract.

(4) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the Association, in the case of contracts assumed under subdivision (1) of this subsection (n), subject to the following:

(i) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

(ii) the obligations described in subdivision (1) of this subsection (n) shall no longer apply with respect to matters arising after the effective date of the transfer; and

(iii) notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days prior to the effective date of the transfer.

(5) The provisions of this subsection shall supersede the provisions of any State law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to

any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

(6) Except as otherwise provided in this section, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall:

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

(B) give a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

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

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

(o) 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 chapter in an economical and efficient manner.

(p) Where the Association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the

Association's obligations under this chapter, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

(q) Venue in a suit against the Association arising under this chapter shall be in the Civil Division of the Washington Superior Court. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

(r) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection (a) or (b) of this section, the 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 in accordance with all of the following provisions:

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

(A) a fixed interest rate;

(B) payment of dividends with minimum guarantees; or

(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.

§ 4179. 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 times and for such amounts as the Board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at nine percent per annum on and after the due date.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative 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.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under section 4178 of this chapter with regard to an impaired or insolvent insurer.

(c)(1) 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.

(2) The amount of a Class B assessment, except assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, 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.

(3) 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 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers.

(4) Class B assessments against member insurers for each account and subaccount 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 insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired, bears to premiums received on business in this State for those calendar years by all assessed member insurers.

(5) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) 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 180 days after the assessment is authorized.

(d) 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 insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

(e)(1)(A) Subject to the provisions of subdivision (1)(B) of this subsection (e), the total of all assessments authorized by the Association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in one calendar year exceed two percent of that member insurer's average annual premiums received in Vermont on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

(B) If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision (1)(A) of this subsection (e) shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(C) If the maximum assessment, together with the other assets of the Association in an account, does not provide in one year in either account an

amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(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.

(3) If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to subdivision (c)(2) of this section, the Board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (1) of this subsection.

(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 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.

(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 chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(h) The Association shall issue to each member insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount 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.

(i)(1) 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.

(2) Within 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.

(3) Within 30 days after a final decision has been made, the Association shall notify the protesting member insurer in writing of that final decision. Within 60 days after 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 power under this section and member insurers shall promptly comply with a request.

§ 4180. PLAN OF OPERATION

(a)(1) The Association shall submit to the Commissioner a plan of operation and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments to the plan shall become effective upon approval in writing by the Commissioner.

(2) If the Association fails to submit a suitable plan of operation within 120 days following the effective date of this chapter or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. 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.

(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 chapter:

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

(2) establish the amount and method of reimbursing members of the Board of Directors under section 4177 of this chapter;

(3) establish regular places and times including virtual conference calls for meetings 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 will be made and submitted to the Commissioner;

(6) establish any additional procedures for assessments under section 4179 of this chapter;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the Association;

(8) establish procedures whereby a Director may be removed for cause, including in the case where a member insurer Director becomes an impaired or insolvent insurer; and

(9) require the Board of Directors to establish a policy and procedures for addressing conflicts of interests.

(d) The plan of operation may provide that any or all powers and duties of the Association, except those under subdivision 4178(l)(3) and section 4179 of this chapter, are delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this Association, or

its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the Board of Directors and the Commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this chapter.

§ 4181. DUTIES AND POWERS OF THE COMMISSIONER

(a) In addition to the duties and powers enumerated elsewhere in this chapter, the Commissioner shall:

(1) Upon the request of the Board of Directors, provide the Association with a statement of the premiums in Vermont and in any other appropriate states for each member insurer.

(2) Notify the Board of Directors of the existence of an impaired or insolvent insurer not later than three days after a determination of impairment or insolvency is made or the Commissioner receives notice of impairment or insolvency.

(3) 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 such demand shall not excuse the Association from the performance of its powers and duties under this chapter.

(4) In any liquidation or rehabilitation proceeding involving a domestic 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 shall be appointed conservator.

(b) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in Vermont of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. Such forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $500.00 per month.

(c) A final action of the Board of Directors or the Association may be appealed to the Commissioner by a member insurer if such appeal is taken within 60 days following its receipt of notice of the final action being appealed. A final action or order of the Commissioner shall be subject to judicial review in the Vermont Supreme Court.

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

§ 4182. PREVENTION OF INSOLVENCIES

(a) To aid in the detection and prevention of member insurer impairment or insolvency, it shall be the duty of the Commissioner to:

(1) Notify the commissioners of all the other states within 30 days following the action taken or the date the action occurs when the Commissioner takes any of the following actions against a member insurer:

(A) revocation of license;

(B) suspension of license; or

(C) makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from Vermont, 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.

(2) Report to the Board of Directors when the Commissioner has taken any of the actions set forth in subdivision (1) of this subsection or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the Board of Directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) Report to the Board of Directors when the Commissioner has reasonable cause to believe from an examination, whether completed or in

process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(4) Furnish to the Board of Directors the NAIC Insurance Regulatory Information System ratios and listings of companies not included in the ratios 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. The 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.

(b) The Commissioner may seek the advice and recommendations of the Board of Directors concerning any matter affecting the duties and responsibilities of the Commissioner regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in Vermont.

(c) The Board of Directors, upon majority vote, may 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 Vermont. Such reports and recommendations shall not be considered public documents.

(d) The Board of Directors, upon majority vote, shall notify the Commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(e) The Board of Directors, upon majority vote, may make recommendations to the Commissioner for the detection and prevention of member insurer insolvencies.

(f) The Board of Directors shall, at the conclusion of any insurer impairment or insolvency in which the Association carried out its duties under this chapter or exercised any of its powers under this chapter, prepare a report on the history and causes of such impairment or insolvency, based on the information available to the Association, and submit such report to the Commissioner.

§ 4183. CREDITS FOR ASSESSMENTS PAID

(a) A member insurer may offset against its premium tax liability to Vermont an assessment described in subsection 4179(h) of this chapter to the extent of 20 percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(b) A member insurer that is exempt from taxes referenced in subsection (a) 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 insurer shall remit the excess amount to the Association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

(c) Any sums acquired by refund, pursuant to subsection 4179(f) of this chapter, from the Association that have been written off by contributing insurers and offset against premium taxes as provided in subsection (a) of this section, and are not then needed for purposes of this chapter, shall be paid by the insurer to the Commissioner, who shall deposit them with the State Treasurer for credit to the General Fund.

§ 4184. MISCELLANEOUS PROVISIONS

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

(b)(1) 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 section 4178 of this chapter. 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, except:

(A) upon the termination of the impairment or insolvency of the member insurer; or

(B) upon the order of a court of competent jurisdiction.

(2) Nothing in this subsection shall limit the duty of the Association to render a report of its activities under section 4185 of this chapter.

(c) For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to subsection 4178(k) of this chapter. 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 chapter. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets that the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer pursuant to subsection (c) of this section and consistent with section 7073 of this title, 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 chapter. If the liquidator has not, within 120 days after 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.

(e)(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, the shareholders, contract owners, certificate holders, enrollees, and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyowners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

(2) 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 with interest thereon for funds expended in carrying out its powers and duties under section 4178 of this chapter with respect to the member insurer have been fully recovered by the Association.

(f) If an order for liquidation or rehabilitation of a member insurer domiciled in Vermont 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 following limitations:

(1) A distribution shall not be recoverable if the member insurer shows that, when paid, the distribution was lawful and reasonable and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(2) Any person who 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 the member insurer at the time the distributions were declared shall be liable up to

the amount of distributions that would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(3) The maximum amount recoverable under this subdivision 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.

(g) If any person liable under subdivision (f)(2) of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

§ 4185. EXAMINATION; ANNUAL REPORT

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 request of a member insurer, the Association shall provide the member insurer with a copy of the report.

§ 4186. TAX EXEMPTIONS

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

§ 4187. 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 or omission by them in the performance of their powers and duties under this chapter. This 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.

§ 4188. STAY OF PROCEEDINGS; REOPENING DEFAULT JUDGMENTS

All proceedings in which the insolvent insurer is a party in any court in Vermont shall be stayed 180 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 a judgment under any decision, order, verdict, or finding based on the 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.

§ 4189. PROHIBITED ADVERTISEMENT; NOTICE TO POLICY OWNERS

(a) No person, including a member insurer, or 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, that uses the existence of the Insurance Guaranty Association of Vermont for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter. However, this section shall not apply to the Vermont Life and Health Insurance Guaranty Association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

(b) Within 180 days after the effective date of this chapter, the Association shall prepare a summary document describing the general purposes and current limitations of this chapter and complying with subsection (c) of this section. This document shall be submitted to the Commissioner for approval. At the expiration of the 60th day after the date on which the Commissioner approves the document, a member insurer may not deliver a policy or contract to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate

holder, or enrollee at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, contents, or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The document shall be revised by the Association as amendments to the chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

(c) The document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall establish the form and content of the disclaimer. The disclaimer shall:

(1) state the name and address of the Association and the Department of Financial Regulation;

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

(3) state the types of policies or contracts for which guaranty funds will provide coverage;

(4) state that the member 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 or health maintenance organization coverage;

(5) state that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the Association when selecting an insurer or health maintenance organization;

(6) explain rights available and procedures for filing a complaint to allege a violation of any provision of this chapter; and

(7) provide other information as directed by the Commissioner, including sources for information about the financial condition of insurers, provided that the information is not proprietary and is subject to disclosure under Vermont's Public Records Act.

(d) A member insurer shall retain evidence of compliance with subsection (b) of this section for so long as the policy or contract for which the notice is given remains in effect.

§ 4190. PROSPECTIVE APPLICATION

(a) This chapter shall apply to all matters relating to any impaired or insolvent insurer for which the Association first became obligated on or after July 1, 2023.

(b) Matters relating to any impaired or insolvent insurer for which the Association first became obligated prior to July 1, 2023, shall be governed by the provisions of this chapter in effect at the time the Association first became obligated for such matters.

Sec. 10. 8 V.S.A. § 7033 is amended to read:

§ 7033. INJUNCTIONS AND ORDERS

(a) A receiver appointed in a proceeding under this chapter may at any time apply for, and any court of general jurisdiction may grant, restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(1) the transaction of further business;

(2) the transfer of property;

(3) interference with the receiver or with a proceeding under this chapter;

(4) waste of the insurer's assets;

(5) dissipation and transfer of bank accounts;

(6) the institution or further prosecution of any actions or proceedings;

(7) the obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders;

(8) the levying of execution against the insurer, its assets or its policyholders;

(9) the making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(10) the withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(11) any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this chapter.

(b) The receiver may apply to a court outside the State for the relief described in subsection (a) of this section.

(c) Notwithstanding subsections (a) and (b) of this section, subsection 7054(a) of this title, or any other provision of this chapter to the contrary, no person, for more than 10 days, shall be restrained, stayed, enjoined, or prohibited from exercising or enforcing any right or cause of action under any pledge, security, credit, collateral, loan, advances, reimbursement, or guarantee agreement or arrangement, or any similar agreement, arrangement, or other credit enhancement to which a federal home loan bank is a party.

(d) A federal home loan bank exercising its rights regarding collateral pledged by an insurer-member shall, within seven days after receiving a redemption request made by the insurer-member, repurchase any of the insurer-member's outstanding capital stock in excess of the amount the insurer-member must hold as a minimum investment. The federal home loan

bank shall repurchase the excess outstanding capital stock only to the extent that it determines in good faith that the repurchase is both of the following:

(1) permissible under federal laws and regulations and the federal home loan bank's capital plan; and

(2) consistent with the capital stock practices currently applicable to the federal home loan bank's entire membership.

(e) Not later than 10 days after the date of appointment of a receiver in a proceeding under this chapter involving an insurer-member of a federal home loan bank, the federal home loan bank shall provide to the receiver a process and timeline for the following:

(1) the release of any collateral held by the federal home loan bank that exceeds the amount that is required to support the secured obligations of the insurer-member and that is remaining after any repayment of loans, as determined under the applicable agreements between the federal home loan bank and the insurer-member;

(2) the release of any collateral of the insurer-member remaining in the federal home loan bank's possession following repayment in full of all outstanding secured obligations of the insurer-member;

(3) the payment of fees owed by the insurer-member and the operation, maintenance, closure, or disposition of deposits and other accounts of the

insurer-member, as mutually agreed upon by the receiver and the federal home loan bank; and

(4) any redemption or repurchase of federal home loan bank stock or excess stock of any class that the insurer-member is required to own under agreements between the federal home loan bank and the insurer-member.

(f) Upon the request of a receiver appointed in a proceeding under this chapter involving a federal home loan bank insurer-member, the federal home loan bank shall provide to the receiver any available options for the insurer-member to renew or restructure a loan. In determining which options are available, the federal home loan bank may consider market conditions, the terms of any loans outstanding to the insurer-member, the applicable policies of the federal home loan bank, and the federal laws and regulations applicable to federal home loan banks.

(g) As used in this section, "federal home loan bank" means an institution chartered under the "Federal Home Loan Bank Act of 1932," 12 U.S.C. 1421, et seq. and "insurer-member" means a member of the federal home loan bank in question that is an insurer.

Sec. 11. 8 V.S.A. § 7065 is amended to read:

§ 7065. FRAUDULENT TRANSFERS PRIOR TO PETITION

(a) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for

rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee, for a present fair equivalent value, and except that a purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment. The Court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

* * *

(e) Notwithstanding subsection (a) of this section, section 7066 of this title, or any other provision of this chapter to the contrary, no receiver or any other person shall avoid any transfer of, or any obligation to transfer, money or any other property arising under or in connection with any pledge, security, credit, collateral, loan, advances, reimbursement, or guarantee agreement or arrangement, or any similar agreement, arrangement, or other credit enhancement to which a federal home loan bank, as defined in section 7033 of

this title, is a party, that is made, incurred, or assumed prior to or after the filing of a successful petition for rehabilitation or liquidation under this chapter, or otherwise would be subject to avoidance under this section or section 7066 of this title; provided, however, that a transfer may be avoided under this section or section 7066 of this title if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

Sec. 12. 8 V.S.A. § 7067 is amended to read:

§ 7067. VOIDABLE PREFERENCES AND LIENS

(a)(1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this chapter, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) A preference may be avoided by the liquidator if:

(A) the insurer was insolvent at the time of the transfer of property;

(B) the transfer of property was made within four months before the filing of the petition;

(C) the creditor receiving it or to be benefited by it or the creditor's agent acting with reference to it had, at the time when the transfer of property was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(D) the creditor receiving transferred property was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he or she held such position, or any shareholder holding directly or indirectly more than five per centum of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, ~~he or she~~ the purchaser or lienor shall have a lien upon the property to the extent of the consideration actually given by ~~him or her~~ the purchaser or lienor. Where a preference by way of lien or security title is voidable, the court may on due notice order the

lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(4) Notwithstanding subdivision (2) of this section, or any other provision of this chapter to the contrary, no receiver or any other person shall avoid any preference arising under or in connection with any pledge, security, credit, collateral, loan, advances, reimbursement, or guarantee agreement or arrangement, or any similar agreement, arrangement, or other credit enhancement to which a federal home loan bank, as defined in section 7033 of this title, is a party.

* * *

Sec. 12a. STUDY; AUTOMOBILE INSURANCE; LABOR RATES; USE OF AFTERMARKET PARTS; BUSINESS PRACTICES

(a) In order to ensure that the business practices of automobile insurance companies in Vermont do not unfairly disadvantage consumers or the automotive repair industry and workforce, generally, the Commissioner of Financial Regulation shall conduct a study of labor rates, the use of aftermarket parts, market conditions, and other business practices identified in this section. The Commissioner shall investigate and make findings and recommendations regarding the following:

(1) The average hourly labor rates charged by ~~automobile repair facilities~~ auto body shops in Vermont on both a statewide and a regional basis;

the rates charged in other jurisdictions, including New York, Massachusetts, and New Hampshire; and the rates paid by automobile insurance companies for repair work in Vermont. Based on this data, the Commissioner shall determine whether Vermont should establish a minimum labor reimbursement rate for both first- and third-party automobile insurance claims and, if so, what that rate should be and how it should be adjusted to reflect market changes such as inflation. ~~In addition, and upon further investigation, the Commissioner shall determine whether insurance reimbursement rates may reflect unlawful market collusion among insurance companies or whether the market share of a particular company in a geographic area presents risks of anticompetitive conduct, and whether additional safeguards are needed to ensure such conduct or practices do not occur.~~

(2) The appraisal practices of automobile insurance companies and whether "independent" appraisals are available to consumers or whether such appraisals are more likely to reflect the financial interests of insurance companies to the detriment of consumers or repairers.

(3) The extent to which an automobile insurance company controls or influences repair work done at ~~a repair~~ an auto body shop chosen by the consumer and how any such control or influence should affect the liability of the insurance company, particularly regarding the quality and safety of the repair work.

(4) The use of direct repair programs, generally, and their impact on both the automobile repair industry and consumers.

(5) The disclosures made to a consumer by an insurance company, both at the point of sale and upon the submission of a claim, as well as the existing consumer information developed and maintained by the Department of Financial Regulation and whether and to what extent additional disclosures are necessary to ensure a consumer is adequately informed of their potential financial exposure under a policy, including with regard to any labor rate differential, material rate differential, hour differential, and rental differential for loss of use.

(6) Whether Insurance Regulation I-79-2 (revised) should be updated to reflect market changes or business practices that may impede the prompt, fair, and equitable settlement of claims in which liability has become reasonably clear. In particular, the Commissioner shall review Section 8 of the regulation, which concerns standards for the settlements of property and physical damage claims, and further clarify the independence of the appraisals under subdivision (A)(1); the ability of an insurer to negotiate with a repairer under subdivision (A)(2); and the ability of an insurer to insist that repairs be done by a specific repairer under subdivision (A)(3). If the Commissioner determines revisions to the regulation are necessary, the Commissioner shall initiate a rulemaking to effectuate those revisions.

(7) The betterment practices of insurance companies and whether the valuation methods employed are legitimate and fair to consumers.

(8) The use of aftermarket or recycled parts in automobile repairs and whether aftermarket parts, in particular, should be certified and whether and to what extent an insurer should be liable for incidental costs related to the use of aftermarket or recycled parts, such as for any necessary modifications, and the notification that should be provided to a consumer regarding the use of aftermarket or recycled parts in a repair.

(9) The number and nature of complaints received by the Department of Financial Regulation with respect to automobile insurance policies. In addition, the Commissioner shall request and the Attorney General shall provide the number and nature of any such complaints received by the Consumer Assistance Program.

(10) Any other acts or practices or market conditions related to insurance coverage for automobile repairs that may reflect an imbalance of power between the insurance company and the consumer or repairer and whether any additional regulatory measures are necessary to prevent anticompetitive behavior and ensure the interests of all parties are adequately protected.

(b) The Commissioner of Financial Regulation shall submit a final report that includes the Commissioner's finding and recommendations under this

section to the House Committee on Commerce and Economic Development and the Senate Committees on Finance and on Judiciary on or before November 15, 2024, and shall submit an interim progress report to the same legislative committees on or before January 15, 2024.

Sec. 13. EFFECTIVE DATE

This act shall take effect on July 1, 2023.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE