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SUMMARY

Ohio Life and Health Insurance Guaranty Association

- Expands Ohio Life and Health Insurance Guaranty Association coverage to include health insuring corporations.
- Expands coverage by the Association to include claims made by health care practitioners.
- Expands coverage by the Association to include owners of unallocated annuity contracts when certain criteria are met.
- Makes changes to the list of contracts and policies that are explicitly excluded from coverage by the Association.
- Increases the coverage cap for unallocated annuity contract holders that are not participants in a governmental retirement plan, from $1 million to $5 million.
- Amends the Ohio Life and Health Insurance Guaranty Association Act (OLHIGAA) concerning what actions the Association is authorized to take with regard to impaired and insolvent insurers.
- Repeals the requirements the Association must follow when a member insurer is an impaired foreign or alien insurer.
- Authorizes the Association, within 180 days of the date of an order of liquidation, 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.
- Removes the cap of $200 per member insurer per calendar year imposed on nonprorated assessments.

- Specifies how Class B assessments are to be allocated between Association life and health insurance accounts.
- Provides a process by which Association members may protest an assessment.
- Increases the maximum additional assessment the Association can impose on member insurers when current assessments are insufficient to meet Association obligations.
- Removes the authority of the Association's board to request the Superintendent to order an examination of any member insurer that the board in good faith believes may be an impaired or insolvent insurer.
- Removes the authority of the board, at the completion of an insolvency, to prepare a report bearing on the causes and history of the insolvency.
- Removes the requirement that member insurers disclose via a notice when a policy they issue is excluded from coverage by the Association.
- Allows insurers that are exempt from premium or franchise taxes to recoup their Association assessments by a surcharge on premiums.
- Excludes, with respect to multiple nongroup policies of life insurance owned by one owner, premiums in excess of $5 million from the definition of "premium," thereby potentially reducing the assessment amounts the Association charges members.

Alternative retirement plan required distributions

- Prohibits a benefit or payment from being paid to an alternative retirement plan (ARP) participant, or the participant's beneficiaries if provided under the ARP or an investment option, before the participant must begin receiving minimum distributions under federal law.
- Specifies that a provider is not required to obtain the consent of an ARP participant's spouse before making minimum distributions required under federal law.

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DETAILED ANALYSIS

Ohio Life and Health Insurance Guaranty Association

Overview

The act amends the law related the Ohio Life and Health Insurance Guaranty Association. The Association was created to provide some level of protection for Ohio consumers against insolvency and instability in the insurance industry. To accomplish this, the Association steps in and pays claims when an insurer is unable to pay them due to insolvency or other financial impairment. The Life and Health Insurance Guaranty Association is composed of life and health insurers; there is a separate guaranty association covering property and liability insurance. Membership in the Association is required of all life and health insurers operating in Ohio. The Association is funded through assessments charged to member insurers, with the size of the assessment being proportional to the size of the insurer.[1]

Terminology

Many of the act's changes are updates to terminology needed to take into account the act's inclusion of unallocated annuity contracts and health insuring corporation business in coverage by the Association. For example, the act refers to "policies and contracts" as opposed to merely "policies." Similarly, it refers to "insureds, enrollees, and annuitants" as opposed to just "insureds," and to "policies and contracts" as opposed to just "policies."[2]

Health insuring corporations

Under prior law, health insuring corporations were explicitly excluded from being member insurers.[3] Accordingly, the Association did not provide any protection when a health insuring corporation defaulted on claims. Under the act, membership in the Association is required for health insuring corporations.[4] For brevity in this analysis, references in the act to "insurers" includes health insuring corporations.

Persons covered

Under continuing law, certificate owners or holders, as well as their beneficiaries, assignees, or payees, are eligible for compensation from the Association. The act explicitly states that health care providers who are owed in relation to a claim are eligible payees.[5]

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[1] Ohio Life & Health Insurance Guaranty Association, available at olhiga.org; R.C. Chapter 3956.

[2] R.C. Chapter 3956.

[3] R.C. 3956.01(F)(2)(a).

[4] R.C. 3956.01(I) and 3956.06.

[5] R.C. 3965.04(A)(1).

The act alters the conditions under which a non-Ohio resident is eligible for Association coverage. Under continuing law, the Ohio Association provides coverage to a non-Ohio resident if all of the following are met:

- The insurer is domiciled in Ohio;
- The insurer did not, at the time the policies or contracts were issued, hold a license or certificate of authority in the person's home state;
- The person's home state has a guaranty association but the person is ineligible for coverage from that association.

The act clarifies that Association coverage for nonresidents is available when the associated insurer is a *member* of the Association (although, as stated in the "**Overview**" above, all life and health insurers in the state must be members of the Association). Furthermore, the person must not be eligible for coverage in their home state due to the fact that the insurer lacked a license or certificate of authority in that state *at the time specified in the person's home state guaranty association laws.*[6]

In addition, the act explicitly provides coverage to the owners of unallocated annuity contracts when certain conditions are met. An unallocated annuity contract is any annuity contract or group annuity certificate that is not issued to and owned by an individual.[7] This coverage is conditioned on the contract meeting either of the following criteria:

- The contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Ohio.
- The contracts are issued to or in connection with government lotteries if the owners are Ohio residents.[8]

Exclusions

The Ohio Health and Life Insurance Guaranty Association Act (OHLIGAA) also specifies exclusions from coverage. Generally speaking, if a person receives coverage from the association of another state, that person is ineligible to receive coverage from the Ohio Association. Specifically, none of the following persons may receive coverage:

- A person who is a payee, or beneficiary, of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state;
- The owner of an unallocated annuity contract, if any coverage is provided by the association of another state to the person;

[6] R.C. 3956.04(A)(2).

[7] R.C. 3956.01(P).

[8] R.C. 3956.04(A)(3).

- A person who acquires rights to receive payments through a structured settlement factoring transaction. A structured settlement factoring transaction is a transfer of structured settlement payment rights (including portions of structured settlement payments) made for consideration by means of sale, assignment, pledge, or other form of encumbrance or alienation for consideration.[9]

The last two of the preceding bullet points are newly added under the act.

Policies covered

Continuing law provides coverage to eligible persons for direct, nongroup life, health, or annuity policies or contracts. The act adds health insuring corporation subscriber policies, contracts, certificates, and agreements to this list and specifies that coverage for health insurance includes sickness and accident insurance policies and contracts.[10]

Prior and continuing law also contain an extensive list of policies that are not eligible for coverage. The act makes numerous changes as follows.

Policies not eligible for Association coverage	
Prior law	**The act**
Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder *(R.C. 3956.04(B)(2)(a)).*	Same, except the act uses the term "member insurer" instead of "insurer" *(R.C. 3956.04(C)(2)(a)).*
Any policy or contract of reinsurance, unless assumption certificates have been issued *(R.C. 3956.04(B)(2)(b)).*	Any policy or contract of reinsurance, unless assumption certificates have been issued *pursuant to the reinsurance policy or contract* *(R.C. 3956.04(C)(2)(b)).*
Any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds certain specified amounts *(R.C. 3956.04(B)(2)(c)).*	Any portion of a policy or contract to the extent that the rate of interest on which it is based*, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value,* exceeds the same specified amounts identified in continuing law. However, this exclusion does not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits. *(R.C 3956.04(C)(2)(c) and (3).)*

[9] R.C. 3956.04(B) and 26 United States Code (U.S.C.) 5891(c)(3)(A).

[10] R.C. 3956.04(C)(1).

Policies not eligible for Association coverage	
Prior law	**The act**
Any portion of a policy or contract to the extent that it provides dividends or experience rating credits *(R.C. 3956.04(B)(2)(e)).*	Any portion of a policy or contract to the extent that it provides dividends, *voting rights,* or experience rating credits *(R.C. 3956.04(C)(2)(e)).*
Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation *(R.C. 3956.04(B)(2)(g)).*	Same, but adds that such a contract is not covered regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan *(R.C. 3956.04(C)(2)(g)).*
Any policy or contract issued to or for the benefit of a past or present director or officer within one year of the filing of the successful complaint that the insurer was impaired or insolvent *(R.C. 3956.04(B)(2)(i)).*	No exclusion.
No exclusion.	Any portion of a policy or contract to the extent that the assessments required under "**Assessments**" below with respect to the policy or contract are preempted by federal or state law *(R.C. 3956.04(C)(2)(i)).*
Any policy or contract issued by any entity that is not a member insurer *(R.C. 3956.04(B)(2)(j)).*	No exclusion.
No exclusion.	Any 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 all of the following: ▪ Claims based on marketing materials; ▪ Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; ▪ Misrepresentations of or regarding policy or contract benefits; ▪ Extra-contractual claims; ▪ A claim for penalties or consequential or incidental damages *(R.C. 3956.04(C)(2)(j)).*

Policies not eligible for Association coverage	
Prior law	**The act**
Any policy or contract issued by a member insurer if the member insurer is carrying on as a line of business, and not as a separate legal entity, the activities of any entity that is not a member insurer, and the policy or contract is issued as a product of those activities *(R.C. 3956.04(B)(2)(k))*.	No exclusion.
No exclusion.	A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer *(R.C. 3956.04(C)(2)(k))*.
Any policy or contract providing hospital, medical, prescription drug, or other health care benefits pursuant to Medicare and any corresponding regulations *(R.C. 3956.04(B)(2)(l))*.	Same, but also includes Medicaid *(R.C. 3956.04(C)(2)(l))*.
No exclusion.	Structured settlement annuity benefits to which a payee (or the beneficiary of a payee, if the payee is deceased) has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction *(R.C. 3956.04(C)(2)(m))*.
No exclusion.	A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under the OLHIGAA, 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, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the

Policies not eligible for Association coverage	
Prior law	The act
	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. *(R.C. 3956.04(C)(2)(n).)*

Limitation on liability

Prior law prohibited the benefits for which the Association may become liable from exceeding the lesser of either of the following:

- The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer;
- $100,000 in health insurance benefits other than basic hospital, medical, and surgical insurance, major medical insurance, disability insurance, or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- $300,000 in disability insurance;
- $500,000 in basic hospital, medical, and surgical insurance or major medical insurance;
- $250,000 for individuals participating in a governmental retirement plan covered by an unallocated annuity;
- $300,000 in the aggregate for any one person all types of coverage listed above except for with regard to basic medical insurance;
- $1 million for any unallocated annuity contract holder that is not a participant in a governmental retirement plan.[11]

The act largely maintains these coverage caps with one exception: It raises the coverage cap for unallocated annuity contract holders that are not participants in a governmental retirement plan from $1 million to $5 million. Additionally, the act makes certain changes to the terminology used. The first bullet point above is revised by referring to “member insurers” instead of “insurer.” Also, instead of referring to “basic hospital, medical, and surgical insurance or major medical insurance,” the act uses the term “health benefit plan coverage,” which includes all plans issued by health insuring corporations and sickness and accident insurers, but excludes certain limited benefit policies, such as accident only insurance, dental or vision

[11] R.C. 3956.04(D).

insurance, or specified disease insurance. And finally, the act refers to "disability income insurance" rather than simply "disability insurance."[12]

The act further provides that the limitations 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. In addition, the costs of the Association's obligations under the OLHIGAA may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.[13]

The act states that for purposes of the OLHIGAA, benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.[14]

Lastly, the act provides that in performing its obligations to provide coverage with regard to impaired and insolvent insurers, the Association is not required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy that do not materially affect the economic values or economic benefits of the covered policy.[15]

Impaired and insolvent insurers

Impaired insurers

The OHLIGAA specifies what actions the Association is authorized to take with regard to impaired insurers. An impaired insurer is an insurer that is not insolvent, but that is placed under an order of rehabilitation or conservation by a court. Continuing law permits the Association to guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of an impaired domestic member insurer. The act adds that the Association may also reissue or cause to be reissued those policies or contracts. It also uses the term "impaired member insurer" rather than "impaired *domestic* member insurer."[16]

In addition, prior law allowed the Association to impose any conditions on any action it took to assure payment of contractual obligations of an impaired insurer if, among other things, the impaired insurer approved the condition (except in the case of a court ordered conservation or rehabilitation). The act no longer requires the impaired insurer's approval.[17]

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[12] R.C. 3956.01(F) and 3956.04(D)(2).

[13] R.C. 3956.04(D)(2)(e).

[14] R.C. 3956.04(G).

[15] R.C. 3956.04(H).

[16] R.C. 3956.01(G) and 3956.08(A)(1)(a).

[17] R.C. 3956.08(A)(2)(c).

Impaired foreign or alien insurers

The act repeals the requirement that, when an impaired foreign or alien member insurer was not paying claims timely, the Association either: [18]

- Guarantee, assume, or reinsure, the impaired contracts; or provide moneys, pledges, notes, guarantees, or other means to assure payment; or
- Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for the following:
  - Death benefits and health claims;
  - Periodic annuity benefit payments;
  - Supplemental benefits; and
  - Cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the Association and approved by the Superintendent of Insurance.[19]

The Association was subject to this requirement only if both of the following applied to the foreign or alien insurer:

- The laws of its state of domicile provided that, until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses and interest, at a rate not less than that allowed under federal law governing interest on civil money judgments, on all such payments and expenses, had been repaid to the guaranty associations or a plan of repayment by the impaired insurer had been approved by the guaranty associations, all of the following applied:
  - The delinquency proceeding could not be dismissed.
  - Neither the impaired insurer nor its assets could be returned to the control of its shareholders or private management.
  - The impaired insurer could not be permitted to solicit or accept new business or have any suspended or revoked license restored.
- The impaired insurer had been prohibited from soliciting or accepting new business in Ohio, its license or certificate of authority had been suspended or revoked in Ohio, and a petition for rehabilitation or liquidation had been filed in a court of competent jurisdiction in its state of domicile by the commissioner of insurance of that state.[20]

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[18] R.C. 3956.08(B), repealed by the act.

[19] R.C. 3956.08(B)(1), repealed by the act.

[20] R.C. 3956.08(B)(2), repealed by the act.

Insolvent insurers

An insolvent insurer is an insurer that has been placed under an order of liquidation by a court with a finding of insolvency.[21] The OHLIGAA specifies how the Association is to respond with regard to insolvent member insurers. Continuing law requires the Association to take one of two specified actions. The act maintains these prescribed actions, but rewords the requirement slightly by specifying that the Association must, at its discretion, do either of the following:

- Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies or contracts or otherwise assure payment of the insolvent insurer's obligations; or
- With respect to only life and health insurance policies, provide benefits and coverages in accordance with the OHLIGAA.

Under the act, the Association may also reissue or cause to be reissued the covered policies or contracts. Additionally, the act removes the provision limiting the provision of benefits and coverages to only life and health insurance policies, effectively expanding this action to also include health insuring corporation policies.[22]

Benefits

Continuing law specifies the steps the Association must take when providing benefits and coverage on behalf of impaired alien or foreign and all insolvent insurers. The act limits these requirements to only insolvent insurers and modifies them slightly. First, it removes the requirement that the Association assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, requiring instead only that payment of benefits be made as they would have been payable by the insolvent insurer.

When providing substitute coverage, the Association may offer either to reissue the terminated coverage or to issue alternative coverage. The act specifies that the coverage is to be at actuarially justified rates.

Similarly, the act specifies that when the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated coverage, the premium is to be actuarially justified and approved by the Superintendent.[23]

Moratorium

The act addresses what the Association may do 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. In that case, the Association may defer

[21] R.C. 3956.01(H).

[22] R.C. 3956.08(B).

[23] R.C. 3956.08(C).

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. This option to defer does not apply to 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.[24]

Appearance or intervention in case of impaired or insolvent insurer

Continuing law allows the Association to appear or intervene before any Ohio court with jurisdiction over an impaired or insolvent insurer or a third party against whom the Association may have a claim due to subrogation. Furthermore, the Association also has the right to appear in a court in another state for the same reasons. The act specifies that the Association may also appear before an *agency* in another state for these matters.

However, when appearing in another state, with regard to subrogation, instead of appearing with regard to a "third party" over whom it may have rights due to subrogation, under the act, the Association may appear with regard to "any person or property" against whom it may have rights through subrogation. And finally, prior law referred to "rights through subrogation of the insurer's policy or contract holders," while the act simply refers to "rights through subrogation or otherwise."[25]

Subrogation

Continuing law provides the Association 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 *holder* of a policy or contract with respect to the policy or contract. In addition to "holder," the act adds "beneficiary, enrollee, or payee." The act also specifically states that the rights include, in the case of a structured settlement annuity, any rights of the annuity's owner, beneficiary, or payee, to the extent of benefits received pursuant to the OLHIGAA, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore. However, these rights do not include rights against any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under the Internal Revenue Code provision regarding gross income calculation in the case of personal injury liability assignments.[26]

The act further provides that if the OLHIGAA's subrogation provisions 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 must 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.[27]

[24] R.C. 3956.08(G)(2)(b).

[25] R.C. 3956.08(J).

[26] R.C. 3956.08(K)(3); 26 U.S.C. 130.

[27] R.C. 3956.08(K)(4).

Lastly, under the act, if the Association has provided benefits with respect to a covered obligation and a person recovers amounts to which the Association has rights as described in the OLHIGAA, the person must pay the Association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the Association.[28]

Association powers

Prior law allowed the Association to exercise, for the purposes of the OLHIGAA and to the extent approved by the Superintendent, the powers of a domestic life or health insurer, but prohibited it from issuing *insurance policies or annuity contracts* other than those issued to perform its obligations under the OLHIGAA. The act allows the Association to exercise, for purposes of the OLHIGAA, and to the extent approved by the Superintendent, the powers of a domestic life *insurer,* health insurer, *or health insuring corporation,* but prohibits it from issuing *policies or contracts* other than those issued to perform its obligations under the OLHIGAA.[29]

The act also adds three powers that were not explicitly provided for under prior law:

- The Association may, 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 the OLHIGAA.
- The Association may organize itself as a corporation or in other legal form permitted by Ohio law.
- The Association may request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under the OLHIGAA with respect to the person. The act requires the person to promptly comply with the request.[30]

Deposit not turned over to liquidator

Under the act, a deposit in Ohio, held pursuant to law or required by the Superintendent 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 Ohio or in a reciprocal state, must, pursuant to the provisions of Ohio law regarding insurer rehabilitation and liquidation, be promptly paid to the Association.[31] The act provides that the Association is entitled to retain a portion of any amount so paid to it. The retained amount is the percentage determined by dividing (1) the aggregate amount of policy or contract owners' claims related to that insolvency for which the Association has provided statutory benefits by (2) the aggregate amount of all policy or contract owners' claims in this state related to that insolvency. The

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[28] R.C. 3956.08(K)(5).

[29] R.C. 3956.08(N)(6).

[30] R.C. 3956.08(N)(8), (10), and (11).

[31] R.C. 3956.08(O)(1); R.C. Chapter 3903, not in the act.

Association must remit to the domiciliary receiver the amount paid to the Association, less the amount retained. Any amount so paid to and retained by the Association must be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.[32]

Reinsurance

The act adds a number of new provisions concerning reinsurance as follows.

In general

At any time within 180 days of 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 is effective as of the date of the order of liquidation. The election must be effected by the Association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHIGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.[33]

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 must make available upon request to the Association or to the NOLHIGA on its behalf as soon as possible after commencement of formal delinquency proceedings both of the following:

- Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed;
- Notices of any defaults under the reinsurance contacts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.[34]

Reinsurance contracts assumed by the Association

The following provisions apply to reinsurance contracts the Association assumes.[35]

The Association is responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and is responsible for performing all other obligations to be performed after the date of the order of liquidation, in each case which relates 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

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[32] R.C. 3956.08(O)(2) and (3).

[33] R.C. 3956.08(P)(1)(a).

[34] R.C. 3956.08(P)(1)(b).

[35] R.C. 3956.08(P)(2).

excess of the obligations of the Association and must provide notice and an accounting of these charges to the liquidator.[36]

The Association is entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the Association. Upon receipt of any such amounts, the Association is 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 the following:

- The amount received by the Association; or
- 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.[37]

Within 30 days following the Association's election, the Association and each reinsurer under contracts assumed by it must 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. The calculation must 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 must 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 must pay any remaining balance due the other, in each case within five days of the completion of the calculation. Any disputes over the amounts due to either the Association or the reinsurer must 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 the paragraph above, the receiver must remit that amount to the Association as promptly as practicable.[38]

If the Association or receiver, on the Association's behalf, within 60 days of 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 is not entitled to do either of the following:

- 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; or

[36] R.C. 3956.08(P)(2)(a).

[37] R.C. 3956.08(P)(2)(b).

[38] R.C. 3956.08(P)(2)(c).

- Set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.[39]

Time period

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, both of the following apply:

- Neither the Association nor the reinsurer has any rights or obligations under reinsurance contracts that the Association has the right to assume, whether for periods prior to or after the date of the order of liquidation. The reinsurer, the receiver, and the Association must, to the extent practicable, provide each other data and records reasonably requested.
- Provided that the Association has elected to assume a reinsurance contract, the parties' rights and obligations are governed by the provisions described in "**In general**" and "**Reinsurance contracts assumed by the Association**" above.[40]

If no assumption of reinsurance contracts

If the Association does not elect to assume a reinsurance contract by the election date, the Association has 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.[41]

Policy and reinsurance transfer

When policies, contracts, or annuities, or covered obligations with respect to them, 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 "**In general**" above, subject to the following:

- Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contracts transferred do not cover any new policies of insurance, contracts, or annuities in addition to those transferred.
- The obligations described in "**In general**" above no longer apply with respect to matters arising after the effective date of the transfer.
- Notice must 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.[42]

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[39] R.C. 3956.08(P)(2)(d).

[40] R.C. 3956.08(P)(3).

[41] R.C. 3956.08(P)(4).

[42] R.C. 3956.08(P)(5).

Provisions supersede other state law or reinsurance contract

The provisions under "**Reinsurance**" 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 remains 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.[43]

Construal of reinsurance provisions

Except as otherwise provided in the act's reinsurance provisions, nothing in those provisions does any of the following:

- Alters or modifies the terms and conditions of any reinsurance contract;
- Abrogates or limits any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract;
- Gives a policy owner, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;
- Limits or affects the Association's rights as a creditor of the estate against the assets of the estate; or
- Applies to reinsurance agreements covering property or casualty risks.[44]

Substitute coverage

The act provides that in carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts, 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 the following provisions:

- In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for any of the following:
  - A fixed interest rate;
  - Payment of dividends with minimum guarantees; or
  - A different method for calculating interest or changes in value.

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[43] R.C. 3956.08(P)(6).

[44] R.C. 3956.08(P)(7).

- There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract.
- The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.[45]

Other provisions

Under the act, the Association's board of directors has discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of the OLHIGAA in an economical and efficient manner.[46]

The act provides that where the Association has arranged or offered to provide the benefits of the OLHIGAA to a covered person under a plan or arrangement that fulfills the Association's obligations under the OLHIGAA, the person is not entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.[47]

Lastly, the act requires venue in a suit against the Association arising under the OLHIGAA to be in Franklin County. The Association is not required to give an appeal bond in an appeal that relates to a cause of action arising under the OLHIGAA.[48]

Assessments

The act amends the law related to the assessments the Association charges to member insurers. Prior law referred to assessments being "made." Under the act, assessments are "authorized and called." An "authorized assessment" refers to a resolution passed by the Association's board of directors, whereby an assessment will be called immediately or in the future from members for a specified amount. A "called assessment" means that the Association has issued a notice to member insurers requiring that an authorized assessment be paid within the time frame set forth in the notice. An authorized assessment becomes a called assessment when the notice is mailed, including by electronic means.[49]

There are two types of assessments: Class A assessments and Class B assessments. Under prior law, Class A assessments were for the purpose of meeting administrative and legal costs and the cost of examinations. Under the act, instead of examinations, Class A assessments are to be used to pay the costs of detecting and preventing member insurer insolvencies. Class B assessments are charged to pay claims and provide coverage. The act makes no changes to the costs that Class B assessments cover.[50]

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[45] R.C. 3956.08(T).

[46] R.C. 3956.08(Q).

[47] R.C. 3956.08(R).

[48] R.C. 3956.08(S).

[49] R.C. 3956.01(B) and (C) and 3956.09(B).

[50] R.C. 3956.09(B).

Assessments can be either prorated, based on the size of each member insurer, or a flat fee, charged equally to each insurer regardless of size. Prior law specified that nonprorated assessments could not exceed $200 per member insurer in any one calendar year. The act removes this cap.[51] For pro-rated assessments, the act requires the Association to notify each member insurer of its anticipated share of an authorized assessment within 180 days after the assessment is authorized.[52]

Class B assessments

Class B assessments collected by the Association are to be split between various accounts. Prior law required the assessments to be allocated among the subaccounts and accounts of the Association pursuant to an allocation formula. The act retains this allocation, but rewords it. The act also exempts premiums related to long-term care insurance from this allocation.[53]

The amount of the Class B assessments for long-term care insurance written by an impaired or insolvent insurer is to be allocated according to a methodology included in the plan of operation and approved by the Superintendent. The methodology is to provide that 50% of the assessment be allocated to sickness and accident and health member insurers and 50% be allocated to life and annuity member insurers.

For the purposes of these requirements, "life and annuity member insurer" means a member insurer for which the sum of its assessable life insurance premiums and annuity premiums is greater than or equal to its assessable health insurance premiums. "Assessable health insurance premiums" includes the member insurer's assessable sickness and accident premiums and health insuring corporation premiums, but excludes its assessable premiums written for disability income insurance and long-term care insurance. For purposes of this definition, assessable premiums must be measured within the state. And finally, "sickness and accident and health member insurer" means any member insurer not defined as a life and annuity member insurer.[54]

Deferred assessments

Continuing law, unchanged by the act, allows the Association to abate or defer any assessment for a particular insurer if the Association determines that payment of the assessment would inhibit the insurer's ability to meet its contractual obligations. The act specifies that once the conditions that caused a deferral have been removed or rectified, the member insurer must pay all assessments that were deferred pursuant to a repayment plan approved by the Association.[55]

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[51] R.C. 3956.09(C).

[52] R.C. 3956.09(C)(3).

[53] R.C. 3956.09(C)(1).

[54] R.C. 3956.09(C)(2).

[55] R.C. 3956.09(D).

Maximum assessment

Continuing law, unchanged by the act, imposes a maximum on the sum of the assessments that the Association may charge to member insurers. Generally speaking, this maximum is set at 2% of premiums collected by the insurer. However, the Association may exceed this cap if the maximum assessment is not sufficient to enable the Association to carry out its responsibilities. Under prior law, when this occurred, the Association was required to allocate the necessary additional amount among the other subaccounts of the life and equity account in an amount no greater than 1% of premiums collected. Under the act, the additional assessment is subject to the 2% threshold of the original assessment.[56]

Protesting assessments

The act provides for member insurers to protest assessments made by the Association. A member insurer that wishes to protest all or part of an assessment must pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment is to be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment must 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.

Within 60 days following the payment of an assessment under protest by a member insurer, the Association is to 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.

Within 30 days after a final decision has been made, the Association must notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the Superintendent.

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 Superintendent for a final decision, with or without a recommendation from the Association.

If the protest or appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member insurer. Interest on a refund due a protesting member insurer is to be paid at the rate actually earned by the Association.[57]

[56] R.C. 3956.09(E)(1) and (E)(2).

[57] R.C. 3956.09(K).

Assessment information

The act specifies that the Association may request information of member insurers in order to aid in the exercise of its power related to assessments and that member insurers must promptly comply with such a request.[58]

Notification to other associations

Continuing law, unchanged by the act, requires the Superintendent to notify the commissioners of insurance of other states when the Superintendent takes certain adverse actions against an insurer, such as revoking or suspending the insurer's license. The act explicitly states that this notice must also be provided to the commissioners of territories of the United States and the District of Columbia, although this was already the case, as "state" means any state, district, commonwealth, territory, insular possession thereof, and any area subject to the legislative authority of the United States.[59] Under prior law, this notice had to be mailed. The act allows the notice to be provided by electronic means as well.[60]

Insurer examinations

Under prior law, the board of the Association was authorized to request that the Superintendent order an examination of any member insurer that the board in good faith believed may be an impaired or insolvent insurer. How and when such an examination was to be conducted was also prescribed. The act removes this authority and all associated provisions.[61]

Insolvency report

Prior law authorized the board, at the completion of an insolvency, to prepare a report bearing on the causes and history of the insolvency. The act removes this authorization.[62]

Creditor

Continuing law, unchanged by the act, specifies that the Association is to be deemed a creditor of an impaired or insolvent insurer insofar as the Association has paid claims or made expenditures on the insurer's behalf. Under the act, as a creditor of the impaired or insolvent insurer, the Association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available, as a credit against contractual obligations.

If the liquidator has not, within 120 days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of

[58] R.C. 3956.09(L).

[59] R.C. 1.59, not in the act.

[60] R.C. 3956.12(A)(1).

[61] R.C. 3956.12(E).

[62] R.C. 3956.12(G).

a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association is entitled to make application to the receivership court for approval of its own proposal to disburse these assets.[63]

Summary document

Continuing law, unchanged by the act, requires the Association to prepare a summary document outlining the general purposes and limitations of the OHLIGAA and submit the summary to the Superintendent. The summary must contain a disclaimer and continuing law prescribes what must be in the disclaimer. The act adds that the disclaimer must include the types of policies or contracts for which the guaranty funds will provide coverage and that it must explain rights available and procedures for filing a complaint to allege a violation of any provisions of the OHLIGAA. Continuing law requires that the disclaimer provide other information as directed by the Superintendent. The act specifies that this includes sources for information about the financial condition of insurers provided that that information is not proprietary and is subject to disclosure under relevant public record's law.[64]

The act requires that member insurers retain evidence of compliance with the summary requirement for so long as the policy or contract for which the notice is given remains in effect.[65]

Disclosure

Prior law required that member insurers disclose via a notice when a policy they issue is excluded from coverage by the Association. The act removes this requirement.[66]

Effect and interpretation

The act specifies that the provisions of the OHLIGAA in effect prior to September 13, 2022, the act's effective date, apply to all matters relating to any impaired insurer or insolvent insurer for which the Association first became obligated before that date.

The provisions of the OHLIGAA in effect on and after that date apply to all matters relating to any impaired insurer or insolvent insurer for which the Association first becomes obligated on or after that date.[67]

Taxes

Continuing law, unchanged by the act, enables an insurer to offset 20% of its Class B assessments against its premium or franchise taxes. The act specifies that a member insurer that is exempt from taxes may recoup its assessments by a surcharge on its premiums in a sum

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[63] R.C. 3956.13(C) and (D).

[64] R.C. 3956.18(C).

[65] R.C. 3956.18(D).

[66] R.C. 3956.18(D).

[67] R.C. 3956.19.

reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the Superintendent.

Amounts recouped are not to be considered premiums for any other purpose, including the computation of gross premium tax, the medical loss ratio, or agent commission. If a member insurer collects excess surcharges, the member insurer is to remit the excess amount to the Association, and the excess amount must be applied to reduce future assessments in the appropriate account.[68]

Board members

The OLHIGAA requires the Association's board of directors to meet certain requirements. One is that three board members must be representatives of the three member insurers that are (1) consolidated corporations (mutual insurance companies that merged or consolidated with a hospital service association) and (2) that write the largest premium volumes of health insurance in Ohio. The act removes the first requirement that the three member insurers be consolidated corporations.

Prior law also required three members to be representatives of "foreign insurers." The act instead uses the term "foreign *member* insurers."[69]

Membership as condition of license; health account

Prior law required all member insurers to be and remain members of the Association as a condition of their authority to transact the business of insurance. The act modifies this requirement slightly by requiring all member insurers to be and remain members of the Association as a condition of their *license or* authority to transact the business of insurance *or health insuring corporation business.*

Continuing law also requires the Association to maintain two specified accounts for purposes of administration and assessment. One is a *health insurance account*. The act removes the term "insurance," thereby requiring a *health account*.[70]

Additional definitions

The act amends what is excluded from the definition of "premiums." Continuing law, unchanged by the act, specifies that "premiums" does not include any amounts received for policies that the Association does not cover. Continuing law specifies that this provision is not to be construed as requiring the exclusion, from assessable premiums, of premiums paid for coverage in excess of interest limitations or of premiums paid for coverages in excess of the limitations with respect to any one individual, any one participant, or any one contract holder. The act appears to maintain this provision, but rewords it.

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[68] R.C. 3956.20(B).

[69] R.C. 3956.07(A).

[70] R.C. 3956.06(A).

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 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner, are excluded from the definition of "premiums."

Current law further excludes any amounts in excess of $1 million received on any unallocated annuity contract not issued under certain governmental retirement plans. The act raises this amount to $5 million.

What is defined as a "premium" comes to bear when the Association determines assessments. In other words, excluding something from a member insurer's collected premiums potentially reduces their associated assessments.

Finally, the act adds the following definition: "Owner of a policy or contract," "policyholder," "policy owner," "contract owner," and "contract holder" 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. "Owner of a policy or contract," "policyholder," "policy owner," "contract owner," and "contract holder" do not include persons with a mere beneficial interest in a policy or contract.[71]

Alternative retirement plan required distributions

The act makes changes regarding federally required minimum distributions from alternative retirement plans (ARPs) provided by public colleges and universities.[72]

Continuing law permits a full-time employee of a public college or university to elect to participate in an ARP rather than the state retirement system that covers the employee (the Public Employees Retirement System, State Teachers Retirement System, or School Employees Retirement System). A college or university enters into an agreement with one or more private providers to administer investment options under an ARP. An ARP is a defined contribution plan qualified under the Internal Revenue Code (IRC) that provides retirement and death benefits to participants.[73] The IRC requires that a participant must begin receiving required minimum distributions from the ARP by the "required beginning date," which is April 1 of the calendar year after the year the participant turns age 72 or the participant retires, whichever is later. Federal law allows a plan to require a participant to begin receiving the required minimum

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[71] R.C. 3956.01(J) and (K).

[72] R.C. 3305.07 and 3305.10.

[73] R.C. 3305.02 and 3305.04, not in the act.

distribution on April 1 of the calendar year after the year the participant turns age 72, regardless of whether the participant has retired.[74]

Payment of benefits under an ARP

Continuing law prohibits a benefit or payment from being made before one of the following occurs:

- The participant dies;
- The participant terminates employment; or
- The participant becomes disabled, if the plan or investment option provides disability coverage.

The act adds that, if the plan or investment option allows it, the plan can begin making required minimum distributions in accordance with federal law.

It appears that under former law, with respect to a retiring participant, the participant had to be both retired and at least age 72 to receive benefits or payments (because, under federal law, the federal required beginning date is April 1 of the calendar year after turning age 72 or retiring, whichever is later). But, under the act, it appears that a plan may require a participant to begin receiving the required minimum distribution beginning on April 1 of the calendar year after the participant turns 72, regardless of whether the participant is still working.[75]

Spousal consent

The act specifies that a provider is not required to obtain the consent of a participant's spouse before making any distribution required under federal law. Under continuing law, a provider otherwise must obtain the spouse's consent before making an ARP payment if the participant is married at the time one or more payments are to commence or the participant dies. The consent may be waived if the spouse cannot be located or for any other reason specified in federal law.[76] Generally, under the I.R.C., a spouse must consent to the form of payment of any benefits chosen by the participant unless the consent cannot be obtained because the spouse cannot be located or for another reason. However, consent is not required for a provider to begin making payment of "immediately distributable" benefits, including required minimum distributions. A minimum distribution must be made when due for the plan to maintain its qualified status.[77]

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[74] 26 U.S.C. 401(a)(9) and 26 Code of Federal Regulations (C.F.R.) 1.401(a)(9)-2, Q-2. See also Retirement Topics – Required Minimum Distributions (RMDs), which may be accessed by conducting a keyword "Required minimum distributions" search on the Internal Revenue Service's website: irs.gov.

[75] R.C. 3305.07.

[76] R.C. 3305.10.

[77] 26 U.S.C. 401(a)(11) and 417(a)(2) and 26 C.F.R. 1.401(a)(9)-8, Q-4.

HISTORY

Action	Date
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Reported, S. Insurance	04-05-22
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