

New Jersey
Insurance Code

TITLE 17B -- INSURANCE ... Subtitle 3 -- Life and Health Insurance Code ... Chapter 32A -- IMPAIRMENT
AND INSOLVENCY

17B:32A-1

"New Jersey life and health insurance guaranty association act"

Sections 2 through 19 of this act* shall be known and may be cited as the "New Jersey Life and Health Insurance Guaranty Association Act."

*Sections 17B:32A- 2 through 17B:32A- 19.

History	L. 1991, c. 208, s 1.
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17B:32A-2

Purpose

a. The purpose of this act is to protect, subject to certain limitations, those persons specified in subsection a. of section 3 of this act* from hardship because of the impairment or insolvency of any member insurer that issued the life and health insurance policies and annuity contracts specified in subsection b. of section 3 of this act.

b. To provide this protection, an association of insurers is created to pay benefits and to continue coverages, as limited by this act, and members of the association are subject to assessment to provide funds to carry out the purposes of this act.

*Section 17B:32A- 3.

History	L. 1991, c. 208, s 2.
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17B:32A-3

Scope of provisions

a. This act shall provide coverage, for the policies and contracts specified in subsection b. of this section, to:

(1) persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees of the persons covered under paragraph (2) of this subsection; and

(2) persons who are owners of or certificate holders under those policies or contracts, or in the case of unallocated annuity contracts, to the persons who are the contract holders and who:

(a) are residents, or

(b) are not residents, but only if:

(i) the insurers which issued the policies or contracts are domiciled in this State;

(ii) those insurers never held a license or certificate of authority in the states in which those persons reside;

(iii) those states have associations and coverage provisions with respect to residency similar to the association created by this act; and

(iv) those persons are not eligible for coverage by those associations.

b. This act shall provide coverage to the persons specified in subsection a. of this section for:

(1) direct, non-group life, health, annuity and supplemental policies or contracts, for certificates under direct group life, health, annuity and supplemental policies and contracts, for individual and group long-term care insurance policies and contracts, and for unallocated annuity contracts, issued by member insurers, except as limited by this act; and

(2) policies or contracts issued by medical service corporations declared to be insolvent or impaired by a court of competent jurisdiction on or after September 1, 1987, but prior to the effective date of this act, except as otherwise limited by this act.

c. This act shall not provide coverage for:

(1) 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;

(2) any policy or contract of reinsurance, unless assumption certificates have been issued;

(3) any portion of a policy or contract to the extent that the rate of interest on which it is based:

(a) averaged over the four-year period prior to the date on which the association becomes obligated with respect to that policy or contract, exceeds the lesser of:

(i) the rate of interest determined by subtracting three 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 association became obligated, or

(ii) the rate of interest specified in the standard valuation law, or the rules of this State for determining the minimum standard for the valuation of policies or contracts issued during the year of insolvency; and

(b) on and after the date on which the association becomes obligated with respect to that policy or contract, exceeds the rate of interest determined by subtracting four percentage points from Moody's Corporate Bond Yield Average as most recently available; except that the limitation of this paragraph shall not preclude the association from providing more extensive coverage if it is proceeding under the authority of section 7 of this act*;

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

(a) a Multiple Employer Welfare Arrangement as defined in the Employee Retirement Income Security Act of 1974 (29 U.S.C. s 1002);

(b) a minimum premium group insurance plan;

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

(d) an administrative services only contract;

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

(6) any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue that policy or contract in this State;

(7) any unallocated annuity contract issued to an employee benefit plan covered by the Pension Benefit Guaranty Corporation and whose benefits will be paid under such system; and

(8) any portion of any unallocated annuity contract which is not issued to or in connection with a specific plan providing benefits to employees or an association of natural persons.

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

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

(2) with respect to any one insured individual, regardless of the number of policies or contracts:

(a) \$500,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;

(b) \$500,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values, but not more than \$100,000 in net cash surrender and net cash withdrawal values for annuity benefits; provided, however, that in no event shall the association be liable to expend more than \$500,000 in the aggregate with respect to any one individual under this paragraph (2); or

(3) with respect to any one unallocated annuity contract, \$2,000,000 in benefits; or

(4) with respect to any one group, blanket, or individual accident or health insurance or group, blanket or individual accident or health insurance policy, unlimited benefits.

e. A provider of health care services, in order to receive payment directly from the association upon a claim of the provider against an insured, shall agree to forgive the insured of 20% of the obligation which would otherwise be paid by the insurer had it not been insolvent. The obligations of solvent insurers to pay all or part of the covered claim are not diminished by the forgiveness provided in this paragraph. The association is not bound by an assignment of benefits executed with respect to the coverage provided by the insolvent insurer. The association may aggregate all claims owed health care providers when negotiating direct payment of claims of all covered individuals.

*Section 17B:32A- 7.

History	L. 1991, c. 208, s 3.
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17B:32A-4

Definitions

As used in this act:

"Account" means either of the two accounts created under subsection b. of section 5 of this act.{Footnote 1}

"Association" means the New Jersey Life and Health Insurance Guaranty Association created in subsection a. of section 5 of this act.

"Commissioner" means the Commissioner of Insurance.

"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 3 of this act, but does not include unearned premium under a health insurance policy or contract.

"Covered policy" means any policy or contract within the scope of this act as provided by section 3 of this act.{Footnote 2}

"Department" means the Department of Insurance.

"Impaired insurer" means a member insurer which, after the effective date of this act: (1) is determined by the commissioner to be potentially unable to fulfill its contractual obligations; or (2) is placed under an order of receivership, rehabilitation or conservation by a court of competent jurisdiction.

"Insolvent insurer" means a member insurer which, after the effective date of this act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Member insurer" means any insurer licensed in this State or which holds a certificate of authority to transact any kind of insurance in this State for which coverage is provided under section 3 of this act, and includes any insurer whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(1) A dental service corporation established pursuant to the provisions of P.L. 1968, c. 305 (C. 17:48C- 1 et seq.);

(2) A dental plan organization established pursuant to the provisions of P.L. 1979, c. 478 (C. 17:48D- 1 et seq.);

(3) A health maintenance organization established pursuant to the provisions of P.L. 1973, c. 337 (C. 26:2J- 1 et seq.);

(4) A fraternal benefit society established pursuant to the provisions of P.L. 1959, c. 167 (C. 17:44A- 1 et seq.);

(5) A mandatory state pooling plan;

(6) A mutual assessment company or any entity that operates on an assessment basis to the extent of the assessment liability of its members;

(7) An insurance exchange; or

(8) An entity similar to any of the above.

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

"Person" means an individual or natural person, corporation, partnership, association or voluntary organization.

"Premiums" means amounts or considerations received in any calendar year on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" shall not include any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection b. of section 3 of this act except that assessable premium shall not be reduced as the result of the application of: paragraph (3) of subsection c. of section 3 relating to interest limitations; or paragraph (2) of subsection d. of section 3 relating to limitations with respect to any one insured individual. "Premiums" shall not include any premiums in excess of \$2,000,000 per contract on any unallocated annuity contract.

"Resident" means a person who resides in this State at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. For the purposes of this act a person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business.

"Supplemental contract" means an agreement entered into for the distribution of policy or contract proceeds.

"Unallocated annuity contract" means: (1) an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under that contract or certificate; or (2) any unallocated life insurance or health insurance funding agreement, where insurance certificates or contracts are not issued to and owned by individuals, except to the extent of any life insurance or health insurance benefits guaranteed to an individual by an insurer under such funding agreement.

{Footnote 1} Section 17B:32A- 5.

{Footnote 2} Section 17B:32A- 3.

History	L. 1991, c. 208, s 4.
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17B:32A-5

Establishment of association

a. There is created a nonprofit legal entity to be known as the New Jersey 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 in this State. Any member insurer shall remain a member insurer for four years after it ceases to hold a certificate of authority or license. The association shall perform its functions under the plan of operation established and approved pursuant to section 9 of this act{Footnote 1} and shall exercise its powers through the board of directors established under section 6 of this act.{Footnote 2} The association shall be under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

b. For purposes of administration and assessment the association shall maintain two accounts:

(1) The life insurance and annuity account which shall include the following subaccounts:

- (a) life insurance subaccount;
- (b) annuity subaccount; and
- (c) unallocated annuity subaccount.

(2) The health insurance account.

{Footnote 1} Section 17B:32A- 9.

{Footnote 2} Section 17B:32A- 6.

History	L. 1991, c. 208, s 5.
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17B:32A-6

Board of directors

- a. There shall be a board of directors of the association which shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one 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 members.
- b. In approving selections or 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 reasonable 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.

History	L. 1991, c. 208, s 6.
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17B:32A-7

Powers and duties of association

a. If a member insurer is an impaired domestic insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not unreasonably impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court ordered receivership, conservation or rehabilitation, also approved by the impaired insurer:

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

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

(3) loan money to the impaired insurer.

b. (1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims in a timely manner, then subject to the preconditions specified in paragraph (2) of this subsection, the association shall, in its discretion, either:

(a) take any of the actions specified in subsection a. of this section, subject to the conditions therein; or

(b) provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health insurance claims, periodic annuity benefit payments, death benefits, 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 commissioner.

(2) The association shall be subject to the requirements of paragraph (1) of this subsection only if:

(a) the laws of the impaired insurer's state or country of domicile provide that, until all payments of, or on account of, the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations,

(i) the delinquency proceeding shall not be dismissed,

(ii) neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management, and

(iii) it shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(b)(i) in the case of a domestic insurer, it has been placed under an order of receivership or rehabilitation by a court of competent jurisdiction in this State, or

(ii) in the case of a foreign or alien insurer, it has been prohibited from soliciting or accepting new contracts in this State, except as approved by the commissioner and as part of a plan of rehabilitation approved by a court of competent jurisdiction.

(3)(a) The limitations of paragraphs (3) and (4) of subsection c. of section 3 of this act{Footnote 1} shall not preclude the association from providing more extensive coverage or guarantees, if it is proceeding under the authority of this section and if that additional coverage is an essential element in allowing a rehabilitation plan to succeed as determined by the commissioner and a court of competent jurisdiction.

(b) The commissioner and the association shall utilize the authority of this section if a reasonable prospect exists that the ultimate liabilities to be paid by the association and its member insurers will be reduced as compared to the present liabilities incurred if the association were to proceed under paragraph (2) of subsection d. of section 3 of this act.{Footnote 1}

(c) In proceeding under paragraph (1) subsection b. of this section, without limitation on any authority or right of the association under this act or any right of contract, the association may enter into agreements with other guaranty associations to secure coordination between associations and performance by those associations with respect to policy or contract holders covered by those associations equivalent to that provided to individuals covered by this act.

(d) In proceeding under paragraph (1) of subsection b. of this section, any funds actually expended by a member insurer for benefits received by a person covered by this act, which were subject to a plan of rehabilitation approved by the commissioner and a court of competent jurisdiction, shall qualify as an assessment under section 8 of this act{Footnote 2} after a final accounting.

(e) When the association is proceeding under paragraph (1) of subsection b. of this section, the court shall authorize the establishment of liens upon policy and contract holder cash surrender values and cash withdrawal values limiting the ability of policy and contract holders to withdraw deposits, surrender their policies or contracts and receive the net cash surrender values and net cash withdrawal values, for a term of not less than three nor more than five years. The court, in establishing liens upon cash surrender values or cash withdrawal values, shall approve such liens upon the motion of the receiver as are necessary to enable the impaired insurer to meet its death and disability claims and fund the necessary operating expenses associated with its receivership to the greatest extent possible with the available assets of the impaired insurer within the time period covered by rehabilitation plan. The standard to be applied by the court with respect to preferential treatment is that all options offered to policy and contract holders must represent the same pro rata claim on the

general account assets of the impaired insurer and be actuarially equivalent in present value terms at the time they are approved.

c. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1)(a) guaranty, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

(b) assure payment of the contractual obligations of the insolvent insurer; and

(c) provide those monies, pledges, guarantees, or other means as are reasonably necessary to discharge those obligations; or

(2) with respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection d. of this section.

d. When proceeding under subparagraph (b) of paragraph (1) of subsection b. or paragraph (2) of subsection c. of this section, the association shall, with respect only to life and health insurance policies or contracts:

(1) assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the impaired or insolvent insurer, for claims incurred:

(a) with respect to group policies or 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 those policies or contracts;

(b) with respect to individual policies or contracts, not later than the earlier of the next renewal date, if any, under those 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 those policies or contracts;

(2) make a diligent effort to provide all known insureds, or group policyholders with respect to group policies or contracts, 30 days notice of the termination of the benefits provided; and

(3) with respect to individual policies or contracts, and with respect to individuals formerly insured under group policies or contracts who are not eligible for replacement group coverage, make available to each known insured, or owner of an individual policy or contract if other than the insured, substitute coverage on an individual basis in accordance with the provisions of paragraph (4) of this subsection, if the insured had a right under law or the terminated policy or contract to convert coverage to individual coverage or to continue an individual policy or contract in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or contract or had a right only to make changes in premium by class.

