CHAPTER 98

AN ACT concerning the "New Jersey Life and Health Insurance Guaranty Association Act" and amending P.L.1991, c.208.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.1991, c.208 (C.17B:32A-2) is amended to read as follows:

C.17B:32A-2 Purpose; protection from hardship.

2. a. The purpose of P.L.1991, c.208 (C.17B:32A-1 et seq.) is to protect, subject to certain limitations, those persons specified in subsection a. of section 3 of P.L.1991, c.208 (C.17B:32A-1 et seq.) from hardship because of the impairment or insolvency of any member insurer that issued the life, health, and annuity policies, plans or contracts specified in subsection b. of section 3 of P.L.1991, c.208 (C.17B:32A-1 et seq.).

b. To provide this protection, an association of member insurers is created to pay benefits and to continue coverages, as limited by P.L.1991, c.208 (C.17B:32A-1 et seq.), and members of the association are subject to assessment to provide funds to carry out the purposes of P.L.1991, c.208 (C.17B:32A-1 et seq.).

2. Section 3 of P.L.1991, c.208 (C.17B:32A-3) is amended to read as follows:

C.17B:32A-3 Provision of coverage.

3. a. P.L.1991, c.208 (C.17B:32A-1 et seq.) 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, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under paragraph (2) of this subsection; and

(2) persons who are owners of or certificate holders or enrollees under those policies or contracts (other than unallocated annuity contracts, and structured settlement annuities) and in each case who:

(a) are residents, or

(b) are not residents, but only if:

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

(ii) those member insurers, health service corporations, hospital service corporations, medical service corporations, or health maintenance organizations 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 P.L.1991, c.208 (C.17B:32A-1 et seq.); and

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

(3) For unallocated annuity contracts specified in subsection b. of this section, paragraphs (1) and (2) of this subsection shall not apply, and P.L.1991, c.208 (C.17B:32A-1 et seq.) shall (except as provided in paragraphs (5) and (6) of this subsection) provide coverage to persons who are the owners of the unallocated annuity contracts:

(a) if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this State; and

(b) issued to or in connection with government lotteries if the owners are residents.

(4) For structured settlement annuities specified in subsection b. of this section, paragraphs (1) and (2) of this subsection shall not apply, and P.L.1991, c.208 (C.17B:32A-1 et seq.) shall (except

as provided in paragraphs (5) and (6) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased) if the payee:

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

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

(i) the contract owner of the structured settlement annuity is a resident or is not a resident but the insurer that issued the settlement annuity is domiciled in New Jersey and the state in which the contract owner resides has an association similar to the association created by P.L.1991, c.208 (C.17B:32A-1 et seq.); and

(ii) the payee (or beneficiary) and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

(5) P.L.1991, c.208 (C.17B:32A-1 et seq.) shall not provide coverage to a person:

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

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

(c) who acquires rights to receive payments through a structured settlement factoring transaction as defined in section 5891 of the federal Internal Revenue Code, 26 U.S.C. s.5891(c)(3)(A), regardless of whether the transaction occurred before or after that section became effective.

(6) P.L.1991, c.208 (C.17B:32A-1 et seq.) is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under P.L.1991, c.208 (C.17B:32A-1 et seq.) is provided coverage under the law of another state, the person shall not be provided coverage under P.L.1991, c.208 (C.17B:32A-1 et seq.). In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary or assignee, P.L.1991, c.208 (C.17B:32A-1 et seq.) shall be construed in conjunction with other state laws to result in coverage by only one association.

b. P.L.1991, c.208 (C.17B:32A-1 et seq.) shall provide coverage to the persons specified in subsection a. of this section for policies or contracts of:

(1) direct, non-group life insurance, health insurance (which for the purposes of P.L.1991, c.208 (C.17B:32A-1 et seq.) includes health service corporation contracts, hospital service corporation contracts, medical service corporation contracts, and health maintenance organization subscriber contracts and certificates), or annuities and supplemental policies or contracts, for certificates under direct group life insurance, health insurance, annuities 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 P.L.1991, c.208 (C.17B:32A-1 et seq.); 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 P.L.1991, c.208 (C.17B:32A-1 et seq.), except as otherwise limited by P.L.1991, c.208 (C.17B:32A-1 et seq.).

c. Except as otherwise provided in subsection d. of this section, P.L.1991, c.208 (C.17B:32A-1 et seq.) shall not provide coverage for:

(1) any portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

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

(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 P.L.1991, c.208 (C.17B:32A-7);

(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 owner 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;

(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;

(9) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which 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 P.L.1991, c.208 (C.17B:32A-1 et seq.), whichever is earlier. If a policy or contract’s interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture;

(10) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Medicare Parts C or D or the Medicaid program, 42 U.S.C. ss.1396 et seq., including the Children’s Health Insurance Program (CHIP) which provides health coverage

to eligible children, either through Medicaid or separate CHIP programs, or any regulations issued pursuant thereto, or the "Family Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or

(11) structured settlement annuity benefits to which a payee (or beneficiary) has transferred rights in a structured settlement factoring transaction as defined pursuant to section 5891 of the federal Internal Revenue Code, 26 U.S.C. s.5891(c)(3)(A), regardless of whether the transaction occurred before or after that section became effective.

d. The exclusion from coverage referenced in paragraph (3) of subsection c. of this section shall not apply to any portion of a policy or contract, including a rider, that provides a long-term care or any other health insurance benefits.

e. The benefits for which the association may become liable 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) with respect to one life, 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;

(5) with respect to each individual participating in a governmental retirement benefit plan established under sections 401, 403(b), or 457 of the U.S. Internal Revenue Code, 26 U.S.C. ss.401, 403(b), and 457, covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $500,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values; and

(6) with respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), $500,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

(7) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the obligation of the association under P.L.1991, c.208 (C.17B:32A-1 et seq.) may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

f. A provider of health care services, in order to receive payment directly from the association upon a claim of the provider against an insured or enrollee, shall agree to forgive the insured of 20% of the obligation which would otherwise be paid by the member insurer had it not been insolvent. The obligations of solvent member insurers to pay all or part of the covered claim are not diminished by the forgiveness provided in this subsection. 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.

3. Section 4 of P.L.1991, c.208 (C.17B:32A-4) is amended to read as follows:

C.17B:32A-4 Definitions.

4. As used in P.L.1991, c.208 (C.17B:32A-1 et seq.):

"Account" means either of the two accounts created under subsection b. of section 5 of P.L.1991, c.208 (C.17B:32A-5).

"Association" means the New Jersey Life and Health Insurance Guaranty Association created in subsection a. of section 5 of P.L.1991, c.208 (C.17B:32A-5).

“Benefit plan” means the benefit plan of a specific employee, union or association of natural persons.

“Called assessment” or “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 timeframe set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

"Commissioner" means the Commissioner of Banking and 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 P.L.1991, c.208 (C.17B:32A-3), but does not include unearned premium under a health insurance policy or contract.

"Covered policy" or “covered contract” means any policy or contract within the scope of P.L.1991, c.208 (C.17B:32A-1 et seq.) as provided by section 3 of P.L.1991, c.208 (C.17B:32A-3).

"Department" means the Department of Banking and Insurance.

“Health benefit plan” means any hospital or medical expense policy or certificate, health service corporation contract, hospital service corporation contract, medical service corporation contract, health maintenance organization subscriber contract, or any other similar health contract. “Health benefit plan” does not include accident-only insurance; credit insurance; dental-only insurance; vision-only insurance; Medicare Supplement income; benefits for long-term care, home health care, community-based care, or any combination thereof; liability insurance, including general liability insurance, or coverage issued as a supplement to liability insurance; disability income insurance; coverage for on-site medical clinics; or 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.

"Impaired insurer" means a member insurer which, after the effective date of P.L.1991, c.208 (C.17B:32A-1 et seq.): (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 P.L.1991, c.208 (C.17B:32A-1 et seq.), is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Member insurer" means any insurer, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization licensed in this State or which holds a certificate of authority to transact any kind of insurance, health service corporation business, hospital service corporation business, medical service corporation business, or health maintenance organization business in this State for which coverage is provided under section 3 of P.L.1991, c.208 (C.17B:32A-3), and includes any insurer, health service corporation, hospital service corporation, medical service corporation, 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:

(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) (Deleted by amendment, P.L.2022, c.98);

(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;

(8) A licensed organized delivery system licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.);

(9) A captive insurer, established pursuant to P.L.2011, c.25 (C.17:47B-1 et seq.); or

(10) 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.

“Owner” of a policy or contract and “policyholder,” “policy owner,” and “contract owner” means 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 of 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.

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

“Plan sponsor” means:

(1) the employer in the case of a benefit plan established or maintained by a single employer;

(2) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(3) in a 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.

"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 P.L.1991, c.208 (C.17B:32A-3) 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 or enrolled 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 an impaired insurer or insolvent insurer and to whom a contractual obligation is owed. For the purposes of P.L.1991, c.208 (C.17B:32A-1 et seq.), 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. A citizen of the United States that is a resident of a foreign country or of a United States possession, territory, or protectorate that does not have an association similar to the association created by P.L.1991, c.208 (C.17B:32A-1 et seq.) shall be deemed a resident of the state of domicile of the member insurer that issued the policies or contracts.

“State” means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

“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.

"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.

4. Section 5 of P.L.1991, c.208 (C.17B:32A-5) is amended to read as follows:

C.17B:32A-5 New Jersey Life and Health Insurance Guaranty Association created.

5. 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 or license to transact insurance, health service corporation business, hospital service corporation business, medical service corporation business, or health maintenance organization business 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 P.L.1991, c.208 (C.17B:32A-9) and shall exercise its powers through the board of directors established under section 6 of P.L.1991, c.208 (C.17B:32A-6). 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 account.

5. Section 6 of P.L.1991, c.208 (C.17B:32A-6) is amended to read as follows:

C.17B:32A-6 Board of directors association.

6. a. There shall be a board of directors of the association which shall consist of not less than seven nor more than eleven 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.

6. Section 7 of P.L.1991, c.208 (C.17B:32A-7) is amended to read as follows:

C.17B:32A-7 Powers of the association.

7. 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 unreasonably impair the contractual obligations of the impaired insurer, that are approved by the commissioner:

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

(2) provide such monies, pledges, notes, 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. (Deleted by amendment, P.L.2022, c.98);

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

(1) (a) guaranty, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, 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 policies or contracts, provide benefits and coverages in accordance with subsection d. of this section.

d. When proceeding under paragraph (2) of subsection c. of this section, the association shall, with respect only to policies or contracts:

(1) assure payment of benefits 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, enrollees, annuitants, or group policy or contract owners 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 an insured, enrollee, or annuitant under group policies or contracts who are not eligible for replacement group coverage, make available to each known insured, enrollee, annuitant, or policy or contract owner of an individual policy or contract if other than the insured, enrollee, or annuitant substitute coverage on an individual basis in accordance with the provisions of paragraph (4) of this subsection, if the insured, enrollee, or annuitant 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 member insurer, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

(4) (a) In providing the substitute coverage required by paragraph (3), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates.

(b) Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

(c) The association may reinsure any alternative or reissued policy or contract.

(5) (a) Alternative policies or contracts adopted by the association shall be subject to the approval of the commissioner.

(b) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged under reasonable actuarial assumptions. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance or coverage to be provided and the age and class of risk of each insured or enrollee.

(c) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(6) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to approval of the commissioner.

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

e. When proceeding under subsection c. of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest at least equal to that specified in paragraph (3) of subsection c. of section 3 of P.L.1991, c.208 (C.17B:32A-3).

f. Nonpayment of premiums within 31 days after the date required, after effective notice shall have been given of the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage, shall terminate the association's obligations under that

policy, contract or coverage under P.L.1991, c.208 (C.17B:32A-1 et seq.) with respect to that policy, contract or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of P.L.1991, c.208 (C.17B:32A-1 et seq.).

g. Premiums due for coverage after entry of an order of receivership or liquidation of any insolvent insurer shall belong to, and be payable at the direction of, the association.

h. The protection provided by P.L.1991, c.208 (C.17B:32A-1 et seq.) shall not apply if any guaranty protection is provided to residents of this State by the law of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

i. In carrying out its duties under subsections b. and c. of this section, the association may, subject to approval by the court:

(1) impose reasonable and necessary policy or contract liens in connection with any guaranty, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this act are less than the amounts needed to assure full and prompt performance of the association's duties under P.L.1991, c.208 (C.17B:32A-1 et seq.), or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of those policy or contract liens, to be in the public interest; or

(2) 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.

j. If the association fails to act within a reasonable period of time as provided in subsections b. and c. of this section, the commissioner shall have the powers and duties of the association provided by P.L.1991, c.208 (C.17B:32A-1 et seq.) with respect to impaired or insolvent insurers.

k. The association may render assistance and advice to the commissioner concerning the receivership, conservation, rehabilitation, liquidation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

l. The association shall have standing to appear before any court in this State with jurisdiction over an impaired or insolvent insurer with respect to which the association is or may become obligated under P.L.1991, c.208 (C.17B:32A-1 et seq.). That standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the termination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court 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.

m. (1) Any person receiving benefits under P.L.1991, c.208 (C.17B:32A-1 et seq.) shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received pursuant to P.L.1991, c.208 (C.17B:32A-1 et seq.), 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 causes of action by any payee, policy or contract owner, beneficiary, insured, enrollee, or annuitant as a condition precedent to the receipt of any right or benefits conferred by P.L.1991, c.208 (C.17B:32A-1 et seq.) upon that 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 P.L.1991, c.208 (C.17B:32A-1 et seq.).

(3) In addition to the rights of subrogation contained in paragraphs (1) and (2) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or policy or contract owner, beneficiary, enrollee, or payee with respect to that policy or contract.

(4) In addition to the rights contained in paragraphs (1), (2) and (3) of this subsection, in the case of any unallocated annuity contract for which benefits are paid by the association under P.L.1991, c.208 (C.17B:32A-1 et seq.), the association shall be deemed to have assigned to it the rights and causes of action of any employee or association of natural persons against the contract owner of such unallocated annuity contract for the amounts paid by the association under P.L.1991, c.208 (C.17B:32A-1 et seq.).

(5) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts (or portion thereof) covered by the association.

(6) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts (or portion thereof) covered by the association.

n. The association may:

(1) enter into any contracts necessary or proper to carry out the provisions and purposes of P.L.1991, c.208 (C.17B:32A-1 et seq.);

(2) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments imposed pursuant to section 8 of P.L.1991, c.208 (C.17B:32A-8) and to settle claims or potential claims against it;

(3) borrow money to effectuate the purposes of P.L.1991, c.208 (C.17B:32A-1 et seq.). Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) employ or retain persons necessary to handle the financial transactions of the association, and to perform other functions as are necessary or proper under P.L.1991, c.208 (C.17B:32A-1 et seq.);

(5) take any legal action necessary to avoid payment of improper claims;

(6) exercise, for the purposes of P.L.1991, c.208 (C.17B:32A-1 et seq.) and to the extent approved by the commissioner, the powers of a domestic life insurer or health insurer, health service corporations, hospital service corporations, medical service corporations, or health maintenance organizations but in no case shall the association issue insurance policies or annuity contracts other than those issued to perform its obligations under P.L.1991, c.208 (C.17B:32A-1 et seq.);

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

(8) request information from a person seeking coverage from the association in order to aid the association in determining its obligations under P.L.1991, c.208 (C.17B:32A-1 et seq.) 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 P.L.1991, c.208 (C.17B:32A-1 et seq.); and

(10) take other necessary or appropriate action to discharge its duties and obligations under P.L.1991, c.208 (C.17B:32A-1 et seq.) or to exercise its powers under P.L.1991, c.208 (C.17B:32A-1 et seq.).

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

p. (1) (a) 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 shall be effective as of the date of the order of liquidation. The election shall be effected by the association or the National Organization of Life and Health Insurance Guaranty Associations (NOLGHA) 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 positions of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association or the NOLGHA 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 contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(c) The following subsubparagraphs shall apply to reinsurance contracts so assumed by the association:

(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 which relate to policies, contracts, or annuities covered, in whole or in part, by the association. The association may charge policies, contracts, or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association 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 those 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 (1) the amount received by the association; and (2) 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 subsubparagraph (ii) of this subparagraph, 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 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 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) the association and the reinsurer shall not have rights or obligations under reinsurance contracts that the association has the right to assume under paragraph (1) of this subsection, whether for period 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 paragraph (1) of this subsection.

(3) If the association does not elect to assume a reinsurance contract by the election date pursuant to paragraph (1) of this subsection, 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 paragraph (1) of this subsection, subject to the following:

(a) 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;

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

(c) 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 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 subsection, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this subsection shall 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. Nothing in this subsection shall limit or affect the association's rights as a creditor of the estate against the assets of the estate. Nothing in this subsection shall apply to reinsurance agreements covering property or casualty risks.

q. 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 P.L.1991, c.208 (C.17B:32A-1 et seq.) in an economical and efficient manner.

r. Where the association has arranged or offered to provide the benefits of P.L.1991, c.208 (C.17B:32A-1 et seq.) to a covered person under a plan or arrangement that fulfills the association's obligations under P.L.1991, c.208 (C.17B:32A-1 et seq.), the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

s. Venue in a suit against the association arising under P.L.1991, c.208 (C.17B:32A-1 et seq.) shall be in Monmouth County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under P.L.1991, c.208 (C.17B:32A-1 et seq.).

t. In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections a., b., c, or d. 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 the following provisions:

(1) in lieu of the index or external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate; payment of dividends with minimum guarantees; or 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; and

(3) the alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

u. A deposit in this State, 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 pursuant to section 57 of P.L.1992, c.65 (C.17B:32-87) 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 the 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.

7. Section 8 of P.L.1991, c.208 (C.17B:32A-8) is amended to read as follows:

C.17B:32A-8 Member insurers assessed to provide funding for association.

8. a. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money, on and after the due date.

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

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs of the association which are not objected to by the commissioner and other expenses. Class A assessments shall also be made, upon the request of the commissioner, for the purpose of meeting costs incurred by or on behalf of the department in the administration of an insolvent insurer to the extent those costs exceed assets of the insolvent insurer available for that purpose. Class A assessments need not be related to a particular impaired or insolvent insurer. The amount of any Class A assessment shall be determined by the board.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under section 7 of P.L.1991, c.208 (C.17B:32A-7) with respect to an impaired or an insolvent insurer. The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among 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 Class B assessments 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.

c. (1) 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 impaired or insolvent, as the case may be, bears to such premiums received on business in this State for such calendar years by all assessed member insurers.

(2) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall be made as necessary to implement the purposes of P.L.1991, c.208 (C.17B:32A-1 et seq.). Classification of assessments under subsection b. of this section and computation of assessments under this subsection c. shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

d. The association shall abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the commissioner, payment of the assessment would endanger the

ability of the member insurer to fulfill its contractual obligations or places the member insurer in an unsafe or unsound financial condition. In the event an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which that assessment is abated or deferred shall 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 commissioner.

e. (1) The total of all assessments imposed under subsection b. of this section upon a member insurer for the life insurance and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent and for the health account shall not in any one calendar year exceed two percent of that member insurer's average premiums, as reported in the annual statement in a form prescribed by the commissioner, received in this State on the policies and contracts covered by the account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by P.L.1991, c.208 (C.17B:32A-1 et seq.).

(2) If a one percent assessment for any subaccount of the life insurance and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to paragraph (1) of subsection c. of this section, the board shall assess all subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in paragraph (1) of this subsection.

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

f. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of an account exceed the amount the board, with the concurrence of the commissioner, finds is necessary to carry out during the coming year the obligations of the association with respect to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

g. Except for that portion of assessments that may be offset against premium taxes pursuant to section 18 of P.L.1991, c.208 (C.17B:32A-18), it shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance, health service corporation business, hospital service corporation business, medical service corporation business, or health maintenance organization business within the scope of P.L.1991, c.208 (C.17B:32A-1 et seq.), to consider the amount reasonably necessary to meet its assessment obligations under P.L.1991, c.208 (C.17B:32A-1 et seq.).

h. The association shall issue to each member insurer paying an assessment pursuant to P.L.1991, c.208 (C.17B:32A-1 et seq.), other than a Class A assessment, a certificate of contribution, in a form and manner prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amount or date of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and manner and for such amount 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 of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

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

8. Section 9 of P.L.1991, c.208 (C.17B:32A-9) is amended to read as follows:

C.17B:32A-9 Plan of operation.

9. a. (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or at the expiration of 30 days after submission if it has not been disapproved.

(2) If the association fails to submit a suitable plan of operation within 120 days following the effective date of P.L.1991, c.208 (C.17B:32A-1 et seq.) or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt such plan or amendments necessary to effectuate the provisions of P.L.1991, c.208 (C.17B:32A-1 et seq.). The plan or amendments 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 P.L.1991, c.208 (C.17B:32A-1 et seq.):

(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 subsection c. of section 6 of P.L.1991, c.208 (C.17B:32A-6);

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

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

(5) establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(6) establish any additional procedures for the imposition of assessments under section 8 of P.L.1991, c.208 (C.17B:32A-8);

(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 for the delegation of any or all powers and duties of the association, except those set forth in paragraph (3) of subsection m. of section 7 of P.L.1991, c.208 (C.17B:32A-7) and section 8 of P.L.1991, c.208 (C.17B:32A-8), to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more other 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 d. shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable or effective than that provided by P.L.1991, c.208 (C.17B:32A-1 et seq.).

9. Section 10 of P.L.1991, c.208 (C.17B:32A-10) is amended to read as follows:

C.17B:32A-10 Additional duties, powers of commissioner.

10. a. In addition to the duties and powers enumerated elsewhere in P.L.1991, c.208 (C.17B:32A-1 et seq.), the commissioner shall:

(1) upon request of the board of directors, provide the association with a statement of the premiums in this State and any other appropriate states for each member insurer;

(2) when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with a demand shall not excuse the association from the performance of its powers and duties under P.L.1991, c.208 (C.17B:32A-1 et seq.);

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

b. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a penalty on any member insurer which fails to pay an assessment when due. That penalty shall not exceed five percent of the unpaid assessment per month, but no penalty shall be less than $100 per month.

c. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if that appeal is taken within 60 days of its receipt of notice of the final action being appealed. If a member insurer is appealing an assessment, the amount assessed shall be paid to the association and made available to meet association obligations during the pendency of an appeal. If the appeal of an assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Any final action or

order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

d. The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of P.L.1991, c.208 (C.17B:32A-1 et seq.).

10. Section 11 of P.L.1991, c.208 (C.17B:32A-11) is amended to read as follows:

C.17B:32A-11 Detection, prevention of insurer insolvencies, impairments.

11. a. To aid in the detection and prevention of member insurer insolvencies or impairments, the commissioner may:

(1) notify the commissioners of insurance or comparable officials of all the other states, territories of the United States and the District of Columbia within 30 days when he takes any of the following actions against a member insurer:

(a) revokes its certificate of authority or license;

(b) suspends its certificate of authority or license; or

(c) makes any formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from this State, reinsure all or part of its business, or increase capital, surplus, or any other account for the security of policy or contract owners, certificate holders, or creditors.

Notice shall be made in any form the commissioner deems appropriate, including notification under the auspices of the National Association of Insurance Commissioners, hereinafter referred to as NAIC.

(2) report to the board of directors when he has taken any of the actions set forth in paragraph (1) of this subsection or has received notification from the commissioner of insurance or comparable official of any other jurisdiction that any such action has been taken in that jurisdiction. The report to the board of directors shall contain all significant details of the action taken or of any such notification received from another jurisdiction.

(3) report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the member insurer may be an impaired or insolvent insurer. The report and the information therein shall be kept confidential by the board of directors.

(4) furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and a list of companies not included in the ratios developed by the NAIC. The board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and 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 member insurers, health service corporations, hospital service corporations, medical service corporations, or health maintenance organizations seeking admission to transact business in this State.

c. The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, conservation or receivership of any member insurer or germane to the solvency of any insurer, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization seeking to do business in this State. Reports and recommendations made pursuant to this subsection shall not be considered public documents.

d. The board of directors may, upon majority vote, notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

e. (Deleted by amendment, P.L.2022, c.98).

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

g. (Deleted by amendment, P.L.2022, c.98).

11. Section 12 of P.L.1991, c.208 (C.17B:32A-12) is amended to read as follows:

C.17B:32A-12 Liabilities of impaired, insolvent insurers.

12. a. Nothing in P.L.1991, c.208 (C.17B:32A-1 et seq.) or P.L.2022, c.98 (C.17B:32A-2 et al.) shall be construed to reduce the liability for unpaid assessments of the insureds or enrollees of an impaired or insolvent insurer operating under a plan with assessment liability.

b. Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 7 of P.L.1991, c.208 (C.17B:32A-7). Records of those negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving an impaired or insolvent insurer, upon the termination of the impairment or insolvency of the member insurer, or upon the order of a court of competent jurisdiction.

c. For the purpose of carrying out its obligations under P.L.1991, c.208 (C.17B:32A-1 et seq.), the association shall be deemed to be a creditor of an impaired or insolvent insurer to the extent of assets attributable to covered policies or contracts reduced by any amounts to which the association is entitled as subrogee pursuant to subsection m. of section 7 of P.L.1991, c.208 (C.17B:32A-7). Assets of an impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer as required by P.L.1991, c.208 (C.17B:32A-1 et seq.). For purposes of this subsection, assets attributable to covered policies or contracts are that proportion of the assets which the reserves that should have been established for such policies or contracts bears to the reserves that should have been established for all policies or contracts of insurance or health benefit plans written by the impaired or insolvent insurer.

d. As a creditor of the impaired or insolvent insurer as established in subsection c. of this section and consistent with section 33 of P.L.1992, c.65 (C.17B:32-63), 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 P.L.1991, c.208 (C.17B:32A-1 et seq.). 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 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.

(1) Prior to the termination of any receivership, liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, enrollees, certificate holders, and policy or contract owners of an insolvent insurer, and any other party with a bona fide interest in making an equitable distribution of the ownership rights of that insolvent insurer. In making such a determination, consideration shall be given to the welfare of the policy or contract owners,

enrollees, and certificate holders, and to the reasonable requirements of a continuing or successor member insurer.

(2) No dividend or other distribution to stockholders or policyholders 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 7 of P.L.1991, c.208 (C.17B:32A-7) with respect to that member insurer have been recovered by the association.

e. (1) If an order for liquidation or rehabilitation of a member insurer domiciled in this State has been entered, the receiver appointed under that order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) through (4) of this subsection.

(2) No such distribution shall be recoverable if the member insurer shows that the distribution was lawful and reasonable when paid, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount in excess of all other available assets of the insolvent insurer needed to pay the contractual obligations of the insolvent insurer.

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

12. Section 13 of P.L.1991, c.208 (C.17B:32A-13) is amended to read as follows:

C.17B:32A-13 Association subject to examination, regulation.

13. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than 120 days after the close of the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon request of a member insurer, the association shall provide a copy of the report.

13. Section 15 of P.L.1991, c.208 (C.17B:32A-15) is amended to read as follows:

C.17B:32A-15 Immunity from liability.

15. a. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under P.L.1991, c.208 (C.17B:32A-1 et seq.). 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.

b. With respect to any impairment or insolvency of a health service corporation created pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), the association shall have no cause of action against any not-for-profit or nonprofit corporation that is regulated by a law governing the conduct of not-for-profit or nonprofit corporations, except in the event of willful or wanton conduct, unless the not-for-profit or nonprofit corporation is a provider of health care services as defined in section 1 of P.L.1985, c.236 (C.17:48E-1). For purposes of this subsection, "willful or wanton conduct" means a course of action which shows the actual or deliberate intent to cause harm.

14. Section 16 of P.L.1991, c.208 (C.17B:32A-16) is amended to read as follows:

C.17B:32A-16 Stay of proceedings involving insolvent insurer.

16. Upon application and notice, all proceedings in which an insolvent insurer is a party or is obligated to defend a party in any court in this State shall be stayed for 180 days and any additional time thereafter as may be determined by the court from the date the insolvency is determined or any ancillary proceeding is initiated in the State, whichever is later, to permit proper defense by the association of all pending causes of action. With respect to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict or finding set aside by the court in which the judgment, order, decision, verdict or finding is entered and shall be permitted to defend against the claim on the merits.

15. Section 17 of P.L.1991, c.208 (C.17B:32A-17) is amended to read as follows:

C.17B:32A-17 Association shall not be used to promote insurance sales.

17. a. No person, including a member insurer, agent or affiliate of a member insurer or insurance producer shall make, publish, disseminate, circulate or place before the public or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by P.L.1991, c.208 (C.17B:32A-1 et seq.). This subsection shall not apply to the department or the association or to any other entity which does not sell or solicit insurance or coverage by a health service corporation, hospital service corporation, medical service corporation, or health maintenance organization.

b. Within 180 days of the effective date of P.L.1991, c.208 (C.17B:32A-1 et seq.), the association shall prepare a summary document describing the general purposes and current limitations of P.L.1991, c.208 (C.17B:32A-1 et seq.) which complies with subsection c. of this section. This document shall be submitted to the commissioner for approval. Sixty days after receiving that approval, no member insurer may deliver a policy or contract described in subsection b. of section 3 of P.L.1991, c.208 (C.17B:32A-3) to a policy or contract owner, certificate holder, or enrollee unless the document is delivered to the policy or contract owner, certificate holder, or enrollee prior to or at the time of delivery of the policy or contract. The document should also be available upon request by a policy or contract owner, certificate

holder, or enrollee. The distribution, delivery, contents or interpretation of this document shall not mean that either the policy or the contract or the policy or contract owner, certificate holder, or enrollee thereof would be 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 act may require. Failure to receive this document does not give the policy or contract owner, certificate holder, enrollee, or insured any greater rights than those stated in P.L.1991, c.208 (C.17B:32A-1 et seq.).

c. The document prepared pursuant to subsection b. of this section shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) state the name and address of the association and the department;

(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 this State;

(3) state that the member insurer and its producers 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, health service corporation coverage, hospital service corporation coverage, medical service corporation coverage, or health maintenance organization coverage;

(4) emphasize that the policy or contract owner, certificate holder, or enrollee should not rely on coverage under the association when selecting a member insurer, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization;

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

(6) explain rights available and procedures for filing a complaint to allege a violation of any provisions of P.L.1991, c.208 (C.17B:32A-1 et seq.); and

(7) provide other information as directed by the commissioner, including, but not limited to, sources for information about the financial condition of member insurers provided that the information is not proprietary and is subject to disclosure under P.L.1963, c.73 (C.47:1A-1 et seq.).

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.

16. Section 18 of P.L.1991, c.208 (C.17B:32A-18) is amended to read as follows:

C.17B:32A-18 Member insurer may offset assessments against premium tax liability.

18. a. A member insurer may offset against its premium tax liability, attributable to premiums written in that year, and determined pursuant to section 1 of P.L.1945, c.132 (C.54:18A-1), any assessments for which a certificate of contribution has been issued, pursuant to subsection h. of section 8 of P.L.1991, c.208 (C.17B:32A-8) to the extent of 10% of the amount of those assessments for each of the five calendar years following the second year after the year in which those assessments were paid, except that no member insurer may offset its premium tax liability by more than 20% of its premium tax liability in any one year. If a member insurer should cease doing business in this State, any uncredited assessments may be offset against its premium tax liability for the year in which it ceases to do business in this State.

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 or by a surcharge on its

membership fees (as applicable) 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 insurance producer commission. If a member insurer collects excess surcharges, the member insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

c. Any sums which are acquired by member insurers as the result of a refund from the association pursuant to subsection f. of section 8 of P.L.1991, c.208 (C.17B:32A-8), and which have theretofore been offset against premium taxes as provided in subsection a. of this section, shall be paid by those member insurers to the State as the Director of the Division of Taxation may require. The association shall notify the commissioner and the Director of the Division of Taxation of any refunds made.

d. This section shall not apply in any way to the imposition or collection of, and no offset shall be permitted against, the surtax on premiums authorized pursuant to section 76 of P.L.1990, c.8 (C.17:33B-49).

17. Section 19 of P.L.1991, c.208 (C.17B:32A-19) is amended to read as follows:

C.17B:32A-19 Provisions not applicable to certain insurers.

19. a. The provisions of P.L.1991, c.208 (C.17B:32A-1 et seq.) prior to the effective date of P.L.2022, c.98 (C.17B:32A-2 et al.) shall apply to all matters relating to any impaired insurer or insolvent insurer as defined in section 4 of P.L.1991, c.208 (C.17B:32A-4) for which the association first became obligated under section 7 of P.L.1991, c.208 (C.17B:32A-7) in effect prior to the effective date of P.L.2022, c.98 (C.17B:32A-2 et al.).

b. The provisions of P.L.1991, c.208 (C.17B:32A-1 et seq.) in effect on and after the effective date of P.L.2022, c.98 (C.17B:32A-2 et al.) shall apply to all matters relating to any impaired insurer or insolvent insurer as defined in section 4 of P.L.1991, c.208 (C.17B:32A-4) for which the association first became obligated under section 7 of P.L.1991, c.208 (C.17B:32A-7) on or after the effective date of P.L.2022, c.98 (C.17B:32A-2 et al.).

18. This act shall take effect immediately.

Approved August 12, 2022.