CHAPTER 34

AN ACT concerning annuity policies and contracts and amending P.L.1991, c.208.

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

1. 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 $250,000 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.

2. This act shall take effect immediately.

Approved July 10, 2024.