17B:32A-8

**LEGISLATIVE HISTORY CHECKLIST**
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(New Jersey Life & Health Guaranty)

**NJSA:** 17B:32A-8

**LAWS OF:** 1994 **CHAPTER:** 180

**BILL NO:** A1414

**SPONSOR(S):** Kramer

**DATE INTRODUCED:** February 28, 1994

**COMMITTEE:** **ASSEMBLY:** Insurance

**SENATE:** Commerce

**AMENDED DURING PASSAGE:** No

**DATE OF PASSAGE:** **ASSEMBLY:** June 27, 1994

**SENATE:** November 10, 1994

**DATE OF APPROVAL:** December 20, 1994

**FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:**

**SPONSOR STATEMENT:** Yes

**COMMITTEE STATEMENT:** **ASSEMBLY:** Yes

**SENATE:** Yes

**FISCAL NOTE:** No

**VETO MESSAGE:** No

**MESSAGE ON SIGNING:** No

**FOLLOWING WERE PRINTED:**

**REPORTS:** No

**HEARINGS:** No

Attached: Model Life and Health Insurance Guaranty Association Act.

KBG:pp

P.L.1994, CHAPTER 180, *approved December 20, 1994*
1994 Assembly No. 1414

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

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

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

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 and examinations conducted under the authority of subsection e. of section 11 of this act. 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 this act with respect to an impaired or an insolvent insurer. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts 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.

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 [four] <u>three</u> most recent calendar years for which

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

information is available preceding the year in which the 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 this act. 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 exempt, 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 exempted, abated or deferred, in whole or in part, the amount by which that assessment is exempted, 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.

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 insurance account shall not in any one calendar year exceed two percent of that 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 [four] three calendar years preceding the year in which the 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 this act.

(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 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 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 which may be offset against premium taxes pursuant to section 18 of this act, it shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this act, to consider the amount reasonably necessary to meet its assessment obligations under this act.

h. The association shall issue to each insurer paying an assessment pursuant to this act, 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 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.

(cf: P.L.1991, c.208, s.8)

2. This act shall take effect immediately and shall be retroactive to January 1, 1991.

STATEMENT

This bill amends the "New Jersey Life and Health Insurance Guaranty Association Act" to provide that assessments made on member insurers will be based on premiums received during the three most recent calendar years for which information is available preceding the year a member insurer becomes insolvent or impaired. The act currently bases assessments on the preceding four calendar years.

This change will make the assessment provision of the act consistent with the model Life and Health Insurance Guaranty Association Act adopted by the National Association of Insurance Commissioners (NAIC) and thereby permit the New Jersey association to base its assessments on data collected by the National Organization of Life and Health Insurance Guaranty Associations. This change is to be retroactive to the effective date of the "New Jersey Life and Health Insurance Guaranty Association Act."

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Conforms assessment provision of "New Jersey Life and Health Insurance Guaranty Association Act" to National Association of Insurance Commissioners model act.

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h. The association shall issue to each insurer paying an assessment pursuant to this act, 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 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.

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Conforms assessment provision of "New Jersey Life and Health Insurance Guaranty Association Act" to National Association of Insurance Commissioners model act.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

# ASSEMBLY, No. 1414

# STATE OF NEW JERSEY

DATED: JUNE 13, 1994

The Assembly Insurance Committee reports favorably Assembly, No. 1414.

This bill amends the "New Jersey Life and Health Insurance Guaranty Association Act" to provide that assessments made on member insurers will be based on premiums received during the three most recent calendar years for which information is available preceding the year a member insurer becomes insolvent or impaired. The act currently bases assessments on the preceding four calendar years.

This change will make the assessment provision of the act consistent with the model Life and Health Insurance Guaranty Association Act adopted by the National Association of Insurance Commissioners (NAIC), and thereby permit the New Jersey association to base its assessments on data collected by the National Organization of Life and Health Insurance Guaranty Associations. This change is to be retroactive to the effective date of the "New Jersey Life and Health Insurance Guaranty Association Act."

SENATE COMMERCE COMMITTEE

STATEMENT TO

# ASSEMBLY, No. 1414

# STATE OF NEW JERSEY

DATED: SEPTEMBER 12, 1994

The Senate Commerce Committee reports favorably Assembly, No. 1414.

This bill amends the "New Jersey Life and Health Insurance Guaranty Association Act" to provide that assessments made on member insurers will be based on premiums received during the three most recent calendar years for which information is available preceding the year a member insurer becomes insolvent or impaired. The act currently bases assessments on the preceding four calendar years.

This change will make the assessment provision of the act consistent with the model Life and Health Insurance Guaranty Association Act adopted by the National Association of Insurance Commissioners (NAIC), and thereby permit the New Jersey association to base its assessments on data collected by the National Organization of Life and Health Insurance Guaranty Associations. This change is to be retroactive to January 1, 1991, the effective date of the "New Jersey Life and Health Insurance Guaranty Association Act."

# LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MODEL ACT

## Table of Contents



## Section 1. Title

This Act shall be known and may be cited as the [state] Life and Health Insurance Guaranty Association Act.

**Comment:** This model act is to be distinguished from the NAIC model guaranty association act for property and liability insurance. Although several philosophical and technical differences exist between this bill and the property and liability model act, to the extent possible and appropriate, provisions and the format of the latter are utilized in this model act.

## Section 2. Purpose

A. The purpose of this Act is to protect, subject to certain limitations, the persons specified in Section 3A against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in Section 3B, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

B. To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the Association are subject to assessment to provide funds to carry out the purpose of this Act.

**Comment:** The basic purpose of this model act is to protect policyowners, insureds, beneficiaries, annuitants, payees and assignees against losses (both in terms of paying claims and continuing coverage) which might otherwise occur due to an impairment or insolvency of an insurer. Unlike the property and liability situations, life and annuity contracts in particular are long-term arrangements for security. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar coverage from other insurers. The payment of cash values alone does not adequately meet such needs. Thus it is essential that coverage be continued. In like manner, an insured may be unable to obtain new health insurance or, at least, he may lose protection for prior illness.

## Section 3. Coverage and Limitations

A. This Act shall provide coverage for the policies and contracts specified in Subsection B:

(1) To persons who, regardless of where they reside (except for non-resident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees of the persons covered under Paragraph (2), and

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

(a) Are residents, or

(b) Are not residents, but only under all of the following conditions:

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

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

(iii) The states have associations similar to the association created by this Act; and

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

B. (1) This Act shall provide coverage to the persons specified in Subsection A for direct, non-group life, health, annuity and supplemental policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts and any immediate or deferred annuity contracts.

(2) This Act shall not provide coverage for:

(a) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;

(b) Any policy or contract of reinsurance, unless assumption certificates have been issued;

(c) Any portion of a policy or contract to the extent that the rate of interest on which it is based

(i) Averaged over the period of four (4) years prior to the date on which the Association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two (2) 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 (4) years before the Association became obligated; and

(ii) On and after the date on which the Association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(d) 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 the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or similar entity under

(i) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;

(ii) A minimum premium group insurance plan;

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

(iv) An administrative services only contract;

(e) 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 policy or contract holder, in connection with the service to or administration of the policy or contract;

(f) 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 the policy or contract in this state;

(g) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

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

(i) Any portion of a policy or contract to the extent that the assessments required by Section 9 with respect to the policy or contract are preempted by federal or state law.

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

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

(2) (a) With respect to any one life, regardless of the number of policies or contracts:

(i) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(ii) $100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values;

(iii) $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(b) With respect to each individual participating in a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $100,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(c) With respect to each payee covered by an annuity contract issued by an insurer to provide benefits pursuant to a structured settlement agreement, or beneficiary of each payee if deceased, $100,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

Provided, however, that in no event shall the Association be liable to expend more the $300,000 in the aggregate with respect to any one individual under Paragraphs 2(a), 2(b) and 2(c) above:

(d) With respect to any one contract holder covered by any unallocated annuity contract not included in Paragraph 2(b) above, $5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.

**Comment:** This section and Section 8 are key sections of the Act. Section 3 identifies who and what are covered and not covered by the Act. Section 8 specifies the responsibilities of the Association toward covered persons with covered policies.

Protection of this Act is primarily extended to resident persons but certain non-residents under specific circumstances will be protected by this Act if the insolvent insurer was domiciled in this state.

This model does not apply to reinsurance unless assumption certificates were issued to the direct insureds. Furthermore, it applies only to direct individual or group certificate insurance issued by insurers licensed to transact insurance in this state at any time. Coverage issued by insurers or other entities which have not submitted to the application of a state's regulatory safeguards applying to insurers is excluded from protection by this Act. (See more particularly the definition of member insurer in Section 5.)

The model bill covers life, health and annuity policies and contracts and contracts supplemental thereto. The term health insurance is intended to include "accident and health" insurance, "sickness and accident" insurance, "disability" insurance, etc. The individual state may want to adjust this language to fit its particular terminology. Certificate holders under group contracts are explicitly covered, but group contract holders are not covered; this avoids the possibility of double coverage and indirect coverage of non-resident certificate holders through a resident group contract holder. However, contract holders of unallocated annuity contracts are covered, but no coverage is provided to individuals under unallocated annuity contracts because there is no contractual guaranty by the insurer to specifically identified individuals under such contracts.

Subsection B(2) identifies certain types of contracts or portions of contracts which are specifically not covered by this Act. If a portion of a contract is not covered, the remainder of the contract is covered unless excluded otherwise. Subsection B(2) also provides a ready means by which an individual state can exempt from the Act those policies and contracts issued by insurers or similar organizations deemed appropriate for exemption by such state.

Subsection B(2)(h) excludes coverage for any unallocated annuity contract not used to fund a benefit plan for natural persons or governmental lottery and is intended to exclude from coverage those products commonly referred to as "financial guaranty" products.

Subsection C provides the maximum limitations of the Association's liability by line of business and overall per one life. The limits may be reached through cash surrender payments, benefit payments, or continuing coverage or a combination thereof. The maximum limits for each type of coverage should be set at an appropriate level after review by each state.

## Section 4. Construction

This Act shall be liberally construed to effect the purpose under Section 2 which shall constitute an aid and guide to interpretation.

## Section 5. Definitions

As used in this Act:

A. "Account" means either of the two accounts created under Section 6.

B. "Association" means the [state] Life and Health Insurance Guaranty Association created under Section 6.

C. "Commissioner" means the Commissioner of Insurance of this state.

**Drafting Note:** Insert the title of the chief insurance regulatory official whenever the term "commissioner" appears.

D. "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.

E. "Covered policy" means any policy or contract within the scope of this Act under Section 3.

F. "Impaired insurer" means a member insurer which, after the effective date of this Act, is not an insolvent insurer, and:

(1) Is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations; or

(2) Is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

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

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

(1) A non-profit hospital or medical service organization;

(2) A health maintenance organization;

(3) A fraternal benefit society;

(4) A mandatory state pooling plan;

(5) A mutual assessment company or any entity that operates on an assessment basis;

(6) An insurance exchange; or

(7) Any entity similar to any of the above.

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

J. "Person" means any individual, corporation, partnership, association or voluntary organization.

K. "Premiums" means amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under Section 3B except that assessible premium shall not be reduced on account of Sections 3B(2)(c) relating to interest limitations and 3C(2) relating to limitations with respect to any one individual, any one participant and any one contractholder; provided that "premiums" shall not include any premiums in excess of $5,000,000 on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

L. "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. 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.

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

N. "Unallocated annuity contract" means any 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 the contract or certificate.

**Comment:** This Act covers "insolvent insurers" which are defined to include an insolvent insurer under an order of liquidation issued by a court of competent jurisdiction. An "impaired insurer" is an insurer deemed by the Commissioner to be unable or potentially unable to fulfill its contractual obligations. As will be treated in Section 8 on the powers and duties of the Association, this model bill enables the Association to become involved prior to an actual court order. The finding by the Commissioner that an insurer is impaired, even though not subject to a court proceeding, serves as a triggering mechanism enabling the Association to function. For further discussion see the Comment to Section 8.

Each state will wish to examine its own statutes to determine whether these definitions are applicable and to determine whether some should be deleted and others added. The NAIC is studying the definitions of premiums to determine the appropriate treatment for return premiums and cash surrenders and withdrawals because of various accounting methods presently utilized by insurers.

## Section 6. Creation of the Association

A. There is created a nonprofit legal entity to be known as the [state] Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The Association shall perform its functions under the plan of operation established and approved under Section 10 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the Association shall maintain two (2) accounts:

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

(a) Life insurance account;

(b) Annuity account; and

(c) Unallocated annuity account which shall include contracts qualified under Section 403(b) of the United States Internal Revenue Code.

(2) The health insurance account.

B. The Association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

**Comment:** Each state will wish to examine its own statutes to determine whether a corporate structure would be a more appropriate form for the Association.

## Section 7. Board of Directors

A. The board of directors of the Association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The insurer_members of the board shall be selected by member insurers subject to the approval of the Commissioner. Two (2) persons who must be public representatives as defined herein shall be appointed by the Commissioner to the board of directors. A "public representative" may not be:

(1) An officer, director, stockholder, employee or independent contractor or subcontractor of an insurance company, insurance agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the [insert state] insurance department;

(2) A person required to register in this state under [insert state law provision requiring lobbyists to register]; or

(3) Related to a person described by Paragraphs (1) and (2) above within the second degree of affinity or consanguinity.

Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, for member insurers subject to the approval of the Commissioner, and by the Commissioner for public representatives. 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 sixty (60) days after notice of the organizational meeting, the Commissioner may appoint the initial insurer members in addition to the public representatives.

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

C. Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the Association for their services.

**Comments:** Subsection A provides that the number and term of the members of the board of directors shall be determined in the plan of operation. To avoid problems in initially selecting the board, this section includes a provision for a start-up meeting which will be called by the Commissioner. To determine voting rights at the organizational meeting each member would have one vote. Thereafter the plan of operation will establish the voting procedures, by-laws, etc. governing the conduct of the Association.

Consistent with the comment in Section 6, states which are amending an existing statute should provide for a continuation of the board.

## Section 8. Powers and Duties of the Association

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

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

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

(3) Loan money to the impaired insurer.

B. (1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in Paragraph (2), the Association shall, in its discretion, either:

(a) Take any of the actions specified in Subsection A, subject to the conditions therein; or

(b) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the Association and approved by the Commissioner.

(2) The Association shall be subject to the requirements of Paragraph (1) only if:

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

(i) The delinquency proceeding shall not be dismissed;

(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management;

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

(b) (i) The impaired insurer is a domestic insurer, and it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or;

(ii) The impaired insurer is a foreign or alien insurer, and

- It has been prohibited from soliciting or accepting new business in this state;
- Its certificate of authority has been suspended or revoked in this state; and
- A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.

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

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

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

(c) Provide such monies, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(2) With respect only to life and health insurance policies, provide benefits and coverages in accordance with Subsection D.

D. When proceeding under Subsection B(1)(b) or C(2), the Association shall, with respect to only life and health insurance policies:

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

(a) With respect to group policies, not later than the earlier of the next renewal date under such policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the Association becomes obligated with respect to the policies;

(b) With respect to individual policies, not later than the earlier of the next renewal date (if any) under the policies or one year, but in no event less than thirty (30) days, from the date on which the Association becomes obligated with respect to the policies;

(2) Make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty (30) days notice of the termination of the benefits provided; and

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

(4) (a) In providing the substitute coverage required under Paragraph (3), the Association may offer either to reissue the terminated coverage or to issue an alternative policy.

(b) Alternative or reissued policies 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.

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

(5) (a) Alternative policies adopted by the Association shall be subject to the approval of the Commissioner. The Association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(b) Alternative policies 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. 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 to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(c) Any alternative policy issued by the Association shall provide coverage of a type similar to that of the policy 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, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the Commissioner or by a court of competent jurisdiction.

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

E. When proceeding under Subsection B(1)(b) or C 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 consistent with Section 3B(2)(c).

F. Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy or coverage under this Act with respect to the policy 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 this Act.

G. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association, and the Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

H. The protection provided by this Act shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

I. In carrying out its duties under Subsection B and C, the Association may, subject to approval by the court:

(1) Impose permanent policy or contract liens in connection with any guarantee, 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 this Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(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(1)(b), C and D of this section, the Commissioner shall have the powers and duties of the Association under this Act with respect to impaired or insolvent insurers.

K. The Association may render assistance and advice to the Commissioner, upon his request, concerning rehabilitation, 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 concerning which the Association is or may become obligated under this Act. Such standing shall extend to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over a third party against whom the Association may have rights through subrogation of the insurer's policyholders.

M. (1) Any person receiving benefits under this Act 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 because of this Act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The Association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Act upon such person.

(2) The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Act.

(3) In addition to Paragraphs (1) and (2) above, 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 holder of a policy or contract with respect to such policy or contracts.

N. The Association may:

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

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 9 and to settle claims or potential claims against it;

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

(5) Take such legal action as may be necessary to avoid payment of improper claims;

(6) Exercise, for the purposes of this Act and to the extent approved by the Commissioner, the powers of a domestic life or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform its obligations under this Act.

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.

**Comment:** Along with Section 3, this section is a key to the specific responsibilities of the Association toward covered persons. That responsibility varies by type of policy or contract involved.

The Association is primarily intended to act after the entry of an order of liquidation with the finding of insolvency against a member insurer. However, the Association may act (Section 8A) in the case of an impaired domestic member insurer to guarantee, assume or reinsure any or all policies or otherwise provide money to the member insurer. Note that action under this subsection is not limited to resident policyholders but to all policies or contracts issued by the insurer.

The Association must act under Section 8B even without an order of liquidation if several conditions exist, the most important being a statutory provision for the repayment of the Association prior to the return of the company to shareholder or private control. The Association's role here is the payment of benefits and "hardship" cash withdrawals to covered persons.

It is imperative that each state incorporate these preconditions into its delinquency statutes in order to allow Section 8B to be used. Because there is such variety in delinquency statutes, each state should develop specific language which embodies these concepts and fits in its present framework.

Section 8C details the main role of the Association in the instance of an order of liquidation against an insolvent member insurer. The responsibilities of the Association vary depending on the kind of coverage and type of policy - group or individual. The Association may offer alternative policies or change the premiums or benefits of existing contracts. "New contracts" shall be offered without new underwriting and with coverage for most existing conditions. In order to facilitate the sale of blocks of business for which the Association is responsible, the cooperation of the domestic receiver will be necessary. Each state should review its receivership statutes to make sure that such sales by the Association are permitted and that the receiver will act to accomplish this.

Subsection H relates to the imposition of policy and contract liens, moratoriums, etc. These are devices which have been used in the past in connection with continuation of the insolvent insurer's coverage. Since, by definition, the assets of the insolvent insurer were not adequate to support its contractual obligations, liens were used to reduce those obligations to a level where the assets would be adequate. However, in the past there was no means to infuse additional funds where needed to make whole policyowners, insureds, and beneficiaries. The purpose of the model act is to provide timely payment and protect against losses due to an insolvency, by providing prompt fulfillment of insurance benefits to the extent of the Association's obligations under this Act. To the extent that liens and moratoriums are sanctioned, the model act retreats from this principle.

On the one hand, it can be argued that if liens and moratoriums cannot be used, there will be a run on the assets of the impaired company. In the past this seems to have been true. However, unlike the past, the performance of the insurer's contractual obligations would be guaranteed.

Also, the standard nonforfeiture laws provide that an insurer in its policies shall reserve the right to defer the payment of cash values for a period of six months after demand therefor with surrender of the policy. Similarly, it is common to require an insurer to reserve for a period of six months the right to defer the granting of any policy loan (other than to pay premiums). For those various reasons, the model act does not encourage the use of liens and moratoriums in ordinary situations.

On the other hand, in periods of severe liquidity problems and economic stress, perhaps of even catastrophic proportions, such devices may become essential. While the model bill concentrates on the protection of those to whom the impaired insurer has a contractual obligation, the impact of assessments on the policyholders of assessed companies is also an important consideration (e.g., significant sales of depressed value assets in a tight money market). Consequently Subsection D(1) authorizes the Association to cause to be imposed liens and moratoriums (or other similar means):

(i) If the Court finds that the amounts assessable are less than what is needed, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the use of such tools in the public interest and

(ii) The Court approves the use of the specific lien, moratorium, etc.

This provides a highly flexible mechanism while at the same time it avoids impairing the contractual obligations of the impaired insurer as a routine matter under ordinary economic and financial conditions. The provision also recognizes that while contractual rights of policyowners may not constitutionally be impaired, when the insolvent insurer's obligation under the contract is assumed by another insurer the policyowner has two options. The policyowner may accept the new contract with such liens or moratoriums as permitted by the court, or accept such pro rata payment as is available from the estate of the insolvent insurer.

Furthermore, to provide added flexibility in a temporary situation (e.g., run on assets), Subsection H(2) provides for temporary moratoriums or liens on payment of cash values and policy loans, but not on the payment of other benefits, with the Court's approval.

Subsection K, to enable the Association to protect its interest and the best interests of the policyholders in the handling of an impairment or insolvency, provides that the Association shall have standing to appear in courts with jurisdiction over an insolvent insurer and such standing will extend to any matters concerning the duties of the Association.

Subsection O explicitly recognizes that prompt and efficient discharge of the Association's obligations will be greatly facilitated, especially in multistate insolvencies by acting in concert through the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) to develop and, where appropriate, carry out coordinated plans.

## Section 9. Assessments

A. For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at [insert amount] percent per annum on and after the due date.

B. There shall be two (2) assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of Section 12E. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section 8 with regard to an impaired or an insolvent insurer.

C. (1) The amount of any Class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. A non-pro rata assessment shall not exceed $150 per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts 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.

(2) 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 or policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the 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.

(3) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this Act. Classification of assessments under Subsection B and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

D. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

E. (1) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent (2%) and for the health account shall not in any one calendar year exceed two percent (2%) of the insurer's average premiums received in this state on the policies and contracts covered by the account

during the three (3) calendar years preceding the year in which the 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 this Act.

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

(3) If a one percent (1%) assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to Subsection C(2), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in Subsection E(1) above.

**Editor's Note:** For interpretation of this section, see Guaranty Fund (EX4) Task Force minutes in 1988 *Proceedings of the NAIC*, Volume II, page 335.

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 insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses.

G. It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this Act, to consider the amount reasonably necessary to meet its assessment obligations under this Act.

H. The Association shall issue to each insurer paying an assessment under this Act, other than Class A assessment, a certificate of contribution, in a form 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 amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

**Comment:** When an insurer is impaired or insolvent the member insurers will be assessed on the basis of the premiums they write in the state. This corresponds to the Association's liability which, in most cases, is limited to covered policies of residents. This assessment system provides a base broad enough to meet fairly large demands on the Association. Equally important, since it reflects the market share of each member in the state considered, it is an equitable method of apportioning the burden of the assessments.

The maximum assessment per year may be varied from state to state depending on the size of the base and the concentration of the business. The two percent maximum assessment per year should produce an adequate amount while at the same time not impose an undue strain in any given year on the assessed companies and their policyholders.

In order to prevent further financial difficulties caused by an assessment, Subsection D permits abatement of assessments when such financial difficulties might result. Subsections D and E provide some limitation on the amounts which can be assessed in any given year. If these limits are reached, to fulfill its responsibilities the Association is empowered to borrow funds which later can be repaid out of future assessments.

Subsection G provides that a member insurer may consider in its premium rates and dividend scale an amount reasonably necessary to meet its assessment obligations. This makes it clear that the cost can be ultimately passed on to the policyowners - i.e., to persons who enjoy the protection provided by the Act. Subsection H provides that the Association shall issue to assessed insurers certificates of contribution in the amount levied. The certificates may be carried by an insurer in its annual statement as an asset in such form, amount and period as may be approved by the Commissioner. By permitting the companies to carry these certificates as an asset, to the extent of their estimated value, the impact on member insurers will be lessened.

## Section 10. Plan of Operation

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 unless he has not disapproved it within thirty (30) days.

(2) If the Association fails to submit a suitable plan of operation within 120 days following the effective date of this Act or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:

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

(2) Establish the amount and method of reimbursing members of the board of directors under Section 7;

(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 assessments under Section 9;

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

D. The plan of operation may provide that any or all powers and duties of the Association, except those under Section 8M(3) and Section 9, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two (2) or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this Act.

## Section 11. Duties and Powers of the Commissioner

In addition to the duties and powers enumerated elsewhere in this Act,

A. The Commissioner shall:

(1) Upon request of the board of directors, provide the Association with a statement of the premiums in this 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 insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this Act;

(3) In any liquidation or rehabilitation proceeding involving a domestic 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 insurance 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 forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture 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 the appeal is taken within sixty (60) days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the Association and available to meet Association obligations during the pendancy of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. 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 this Act.

**Comment:** Subsection A(2) requires that the Commissioner give notice of an impairment to the impaired insurer, and hence to its stockholders, and serve a demand that the impairment be made good. If the company and stockholders fail to raise the necessary funds, this will be a factor bearing upon the stockholder's ownership rights under Section 14D.

Subsection A(3) provides that the Commissioner shall be appointed liquidator or rehabilitator of a domestic insurer and conservator of a foreign or alien insurer being liquidated or rehabilitated. This subsection is not needed in those states having the Uniform Insurers Liquidation Act. Requiring the Insurance Commissioner to be the receiver is necessary to obtain the benefits of a "reciprocal" state under the Uniform Act.

Proceedings for the liquidation, rehabilitation or conservation of insurers present several difficulties which the Uniform Insurers Liquidation Act seeks to solve. Briefly, the difficulties have two sources. First, in some states the liquidator, rehabilitator or ancillary receiver may be a person unfamiliar with insurance regulation. Inefficient administration of the proceedings may result.

Second, the laws of more than one state may be applied to the proceedings, particularly regarding ownership of assets and preferences for payment. The result is confusion and inequity in the collection and distribution of the assets. The Uniform Insurers Liquidation Act meets the first source of problems by designating the Insurance Commissioner as the receiver of a domestic insurer or the ancillary receiver of a foreign insurer. To solve the problem of multiple laws and marshalling of assets, the Uniform Act gives the receiver title to the assets. The ancillary receiver is then required to forward all assets to the receiver. The Uniform Act also details the laws under which preferences in the distribution of assets will be determined.

In drafting this model guaranty bill, particular effort was made to avoid (to the extent possible) disrupting existing state liquidation and rehabilitation laws. However, each individual state may want to consider adopting the Uniform Insurers Liquidation Act, if it has not already done so.

## Section 12. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies or impairments,

A. It shall be the duty of the Commissioner

(1) To notify the commissioners of all the other states, territories of the United States and the District of Columbia when the Commissioner takes any of the following actions against a member insurer:

(a) Revocation of license;

(b) Suspension of license; or

(c) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

The notice shall be mailed to all commissioners within thirty (30) days following the action taken or the date on which such action occurs.

(2) To report to the board of directors when the Commissioner has taken any of the actions set forth in Paragraph (1) or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) To report to the board of directors when the Commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the Commissioner or other lawful authority.

B. The Commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance 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 or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents.

D. It shall be the duty of the board of directors, upon majority vote, to notify the Commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

E. The board of directors may, upon majority vote, request that the Commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty (30) days of the receipt of such request, the Commissioner shall begin an examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the Commissioner designates. The cost of the examination shall be paid by the Association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the Commissioner from complying with Subsection A.

The Commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

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

G. The board of directors shall, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commissioner containing such information as it may have in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.

## [Section 13. Credits for Assessments Paid (Tax Offsets) - OPTIONAL

A. A member insurer may offset against its [premium, franchise or income] tax liability (or liabilities) to this state an assessment described in Section 9H to the extent of twenty percent (20%) of the amount of such assessment for each of the five (5) calendar years following the year in which the assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its [premium, franchise, or income] tax liability (or liabilities) for the year it ceases doing business.

B. Any sums which are acquired by refund, pursuant to Section 9F, from the Association by member insurers, and which have been offset against [premium, franchise or income] taxes as provided in Subsection A above, shall be paid by the insurers to this state in such manner as the tax authorities may require. The Association shall notify the Commissioner that refunds have been made.]

**Comment:** Subsection A provides an offset against future premium, franchise or income taxes of assessments, over a five-year period. The timing of the credit is dependent on the year the assessment is paid. It also allows the member insurer to select the applicable tax (premium, franchise or income) against which the credit may be applied and it permits member insurers going out of business to make use of the credit in their final year of operations.

The NAIC model insolvency guaranty bill for property and casualty insurance provides, in Section 16, that rates "shall include amounts sufficient to recoup a sum equal to the amounts paid to the Association ..." It is obvious that life insurance premiums, and premiums for certain forms of health insurance, cannot be changed on existing policyholders. Thus, recoupment is virtually unattainable through existing policy premium rates and building such assessments into rates for future policyholders is not only impractical but unfair to all policyholders. The only suitable and practical method of recoupment available to companies writing life and health insurance lies in offsets against premium or other taxes on such companies. The method suggested in this section is not only equitable to the companies involved but also reduces the impact on state revenue by the partial offset over a period of years. To the extent the recovery from the insolvent company exceeds the tax credit received, the state would be the ultimate beneficiary. Such equitable treatment of assessment for tax purposes would have additional positive effects: (1) the state legislature would have an additional incentive for providing adequate funds for insurance department personnel and administration, and (2) participation in the economic loss would be shared, to some degree, by the general public rather than solely by insureds, thus minimizing what might otherwise be a penalty on thrift and savings. It may be advisable in some jurisdictions to provide a cross-reference to the premium or other tax statutes to avoid questions of conflicting statutory provisions.

Some states allow this credit and others do not. Accordingly, this section is optional, and the NAIC neither endorses nor rejects the tax credit concept. Each state will wish to consider this provision in the light of its own regulatory experience.

## Section 14. Miscellaneous Provisions

A. Nothing in this Act shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

B. 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 8. Records of the negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under Section 15.

C. For the purpose of carrying out its obligations under this Act, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to Section 8M. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Act. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

D. (1) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the Association with interest thereon for funds expended in carrying out its powers and duties under Section 8 with respect to the insurer have been fully recovered by the Association.

E. (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of Paragraphs (2) to (4).

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

(3) Any person who was an affiliate that controlled the 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 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 (2) 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 needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under Paragraph (3) 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.

**Comment:** Subsection A is intended to preserve the assessment liability of the insureds of assessment mutuals.

Subsection B requires that records be kept of negotiations and actions by the Association. The Association should be held publicly accountable for its actions. On the other hand, effective handling of the rehabilitation or liquidation effort requires minimum publicity. Thus, such records will be made public only after the liquidation, rehabilitation or conservation proceeding is terminated, the impairment or insolvency is terminated or there is a prior order by a court of competent jurisdiction.

Since this Act imposes the obligation upon the Association to continue coverage for policyholders of insolvent insurers, the assets of the insolvent insurer ought to be used, to the extent available, for the purpose of continuing such coverage. Subsection C is designed to accomplish this purpose.

Subsection D, in conjunction with Section 11A(2), is intended to prevent the shareholders of an impaired insurer from sitting back and doing nothing and then reaping the benefits of funds put up by the Association. These stockholders should not obtain a more advantageous position than they would have occupied in the absence of this Act. The court is empowered to modify and distribute the ownership rights of an impaired insurer in order to do equity as between the interested parties.

Subsection E is designed to recapture excessive dividend payments to affiliates that exercised control over the insolvent insurer. The NAIC Insurance Holding Company System Regulatory Model Act in large measure prevents improper distribution of dividends by an insurer to its holding company since extraordinary dividends are subject to the prior approval of the Commissioner, and ordinary dividends are required to be reported to the Commissioner. If, however, dividends are paid under circumstances that the insurer should have reasonably known that such payment could reasonably be expected to affect its ability to perform its contractual obligation to its policyholders, the holding company and affiliates should be required to repay such dividends subject to certain reasonable limitations.

If a state has the NAIC Insurance Holding Company System Regulatory Model Act, the definitions therein could be referred to by this subsection. States without the Model Act could incorporate the relevant definitions in this subsection.

## Section 15. Examination of the Association; Annual Report

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 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.

## Section 16. Tax Exemptions

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

## Section 17. Immunity

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the Association or its agents or employees, members of the board of directors, or the Commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under this Act. Such 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.

**Comment:** Each state may wish to review its own statutes to determine whether its Tort Claims Act, if it has one, could be used as an alternative to this section insofar as it applies to the Commissioner or his representative.

**Section 18. Stay of Proceedings; Reopening Default Judgments**

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty (60) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the Association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

**Section 19. Prohibited Advertisement of Insurance Guaranty Association Act in Insurance Sales; Notice to Policyholders**

A. No person, including an insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the Insurance Guaranty Association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the [State] Life and Health Insurance Guaranty Association Act. Provided, however, that this section shall not apply to the [State] Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance. The use of the protection afforded by this Act, other than as provided by this section, by any person in the sale, marketing or advertising of insurance constitutes unfair competition and unfair practices under the [State] unfair trade practices act, and is subject to sanctions imposed in that act.

B. Within 180 days of the effective date of this Act, the Association shall prepare a summary document describing the general purposes and current limitations of the Act and complying with Subsection C of this section. This document shall be submitted to the Commissioner for approval. Unless Subsection D of this section applies, at the expiration of the sixtieth day after the date on which the commissioner approves the document, an insurer may not deliver a policy or contract covered by a guaranty fund to a policy or contract holder unless the summary document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract. The document shall also be available upon request by a policyholder. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the holder of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the Association as amendments to the Act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this Act.

C. The document prepared under Subsection B 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, address and telephone number of the Life and Health Insurance Guaranty Association and insurance department;

(2) Prominently warn the policy or contract holder that the Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(3) State the types of policies for which guaranty funds will provide coverage;

(4) State that the insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(5) State that the policy or contract holder should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer;

(6) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this Act; and

(7) Provide other information as directed by the Commissioner, including but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

D. No insurer or agent may deliver a policy or contract not covered by the Association unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Life and Health Insurance Guaranty Association. The Commissioner shall by rule specify the form and content of the notice.

**Comment:** Subsection A continues the prohibition of using the existence of the Association in the inducement of sale of insurance. However, Subsection B requires notification to new policyholders concerning the general parameters of the association law and responsibility thereunder.

The following form for the disclaimer notice is suggested:

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The [insert name of the Life and Health Insurance Guaranty Association] provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association or the insurance department will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

[Insert addresses of the Association and department.]

Insurers and agents should be required to deliver the document and disclaimer described under Subsections B and C when a customer is solicited if a "free look" period is not required by state law.

## Section 20. Prospective Application

This Act shall not apply to any insurer which is insolvent or unable to fulfill its contractual obligations on the effective date of this Act.

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*Legislative History (all references are to the Proceedings of the NAIC).*

*1971 Proc. I 54, 58, 134, 159, 160-173 (adopted).*
*1976 Proc. I 2, 9, 270, 296-297, 298-312 (amended and reprinted).*
*1977 Proc. II 19, 21, 355, 363 (amended).*
*1978 Proc. I 13, 15, 211, 241 (corrected).*
*1986 Proc. I 9-10, 22, 149, 294-295, 306-322 (amended and reprinted).*
*1987 Proc. II 15, 22, 160, 320 (decertification of 4-account approach).*
*1988 Proc. I 9, 18-19, 157-159, 337-338, 339-354 (amended to create 2 accounts and reprinted).*
*1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 620-621 (amended).*
*1993 Proc. 3rd Quarter 7, 30, 333-334, 341-343, 350-352 (amended).*