17B:32A-1

LEGISLATIVE HISTORY CHECKLIST
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NJSA: 17B:32A-1

(New Jersey
Health Services
Corporation
Individual
Contract
Guaranty Fund)

LAWS OF: 1991 **CHAPTER:** 208

Bill No: A5051

Sponsor(s): Doria and others

Date Introduced: June 24, 1991

Committee: **Assembly:** -----

Senate: -----

Amended during passage: Yes Amendments denoted by asterisks.

Date of Passage: **Assembly:** June 24, 1991 Re-enacted 7-15-91

Senate: June 30, 1991 Re-enacted 7-15-91

Date of Approval: July 15, 1991

Following statements are attached if available:

Sponsor statement: Yes

Committee Statement: **Assembly:** No

Senate: No

Fiscal Note No

Veto Message: Yes

Message on signing: Yes

Following were printed:

Reports: Yes

Hearings: No

(over)

974.90 New Jersey. Governors' Commission on Health Care Costs
I59 Report... October 1, 1990.
1990 Trenton, 1990.

(See especially p.36)

See newspaper clippings--attached:

KBG/SLJ

[SECOND REPRINT]

ASSEMBLY, No. 5051

STATE OF NEW JERSEY

INTRODUCED JUNE 24, 1991

By Assemblymen DORIA, HAYTAIAN, Adubato, Zecker, Catania, Martin, DeCroce, Assemblywoman Farragher, Assemblyman Kelly, Assemblywoman Heck, Assemblymen Franks, Marsella, Gill, Hudak, Deverin, Cohen and Spadoro

AN ACT concerning health service corporations and [1]certain other insurers,[1] amending P.L.1988, c.71 and [1][amending and supplementing][1] P.L.1985, c.236 [1]and supplementing Title 17B of the New Jersey Statutes[1].

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

[1][1. (New section) For purposes of this act:

"Claimant" means any person entitled to receive health care benefits under a covered contract.

"Commissioner" means the Commissioner of Insurance.

"Covered contract" means any individual subscriber contract issued by a health service corporation to a person eligible for coverage under this act pursuant to section 4 of this act. The individual subscriber contract may be a family contract, if issued as a family contract by the health service corporation.

"Department" means the Department of Insurance.

"Fund" means the New Jersey Health Service Corporation Individual Contract Guaranty Fund created by section 2 of this act.

"Health service corporation" means a corporation created pursuant to and in accordance with P.L.1985, c.236 (C.17:48E-1 et seq.).

"Individual contract" or "individual subscriber contract" means a contract of insurance for individuals as those terms are applicable for the purposes of P.L.1985, c.236 (C.17:48E-1 et seq.).

"Insolvent" means that a health service corporation, 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.

"Insurer" means any insurer licensed or which holds a certificate of authority to transact life insurance, health insurance or annuity business in this State, but does not include:

(1) A hospital service corporation established pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.);

(2) A medical service corporation established pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.);

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 thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate floor amendments adopted June 27, 1991.
[2] Assembly amendments adopted in accordance with Governor's recommendations July 15, 1991.

(3) A health service corporation established pursuant to the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.);

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

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

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

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

(8) A mandatory State pooling plan;

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

(10) An insurance exchange; or

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

"Premiums" means amounts received in any calendar year on policies or contracts subject to assessments less premiums, considerations and deposits returned thereon, less dividends and experience credits thereon.]1

1[2. (New section) a. There is created a nonprofit legal entity to be known as the New Jersey Health Service Corporation Individual Contract Guaranty Fund for the purpose of protecting subscribers or dependents of subscribers under covered contracts, or persons who are beneficiaries, assignees or payees of such subscribers, from hardship because of the insolvency of a health service corporation that issued the covered contracts.

b. To provide this protection, the Governor shall, in the event of such insolvency, appoint a trustee, pursuant to subsection a. of section 6 of this act, to: pay benefits and continue coverages under covered contracts, as limited herein; and levy assessments in order to provide monies to carry out the purpose of the fund.]1

1[3. (New section) a. The benefits for which the fund may become liable shall in no event exceed the lesser of:

(1) the contractual obligations for which the health service corporation is liable or would have been liable if it were not insolvent, or

(2) with respect to any one claimant, regardless of the number of covered contracts, $300,000 in benefits.

b. The fund shall pay each individual claimant's aggregate claim amount determined in accordance with the terms of the covered contract, subject to the $300,000 per claimant aggregate payment limit specified in paragraph (2) of subsection a. of this section. If the fund's liability associated with a claimant exceeds $300,000, the fund's payment to providers of health care services shall be prorated. The proration shall be based on each provider's percentage of the total expenses associated with the claim which would have been covered under the covered contract but for the insolvency of the health service corporation.

c. Any person, corporation, partnership, association or other legal entity receiving benefits under this act either directly or indirectly, shall be deemed to have assigned their rights under, and any cause of action relating to, the covered contract to the fund to the extent of the benefits received because of this act. The fund may require a specific assignment to it of such rights and causes of action by any claimant, payee or contract owner as a condition precedent to the receipt of any right or benefits conferred by this act to that person.]1

1[4. (New section) This act shall provide coverage to those persons who are:

a. Residents of this State;

b. Non-residents of this State, if:

(1) the health service corporation which issued the contracts is domiciled in this State;

(2) the health service corporation never held a license or certificate of authority in the states in which those persons reside;

(3) the states in which those persons reside have life and health insurance guaranty association laws which have residency provisions similar to this act; and

(4) those persons are not eligible for coverage by those associations.]1

1[5. (New section) a. The fund shall be under the supervision of the commissioner and shall be subject to the applicable insurance laws of this State.

b. For purposes of administration and assessment, the fund shall be composed of an administrative account and a covered contract account.

c. There shall be no assessments paid to the fund, nor shall any payments be made from the fund, until such time as a court of competent jurisdiction has determined that a health service corporation is insolvent.

d. All insurers shall be and shall remain subject to assessments made for the fund pursuant to the provisions of section 7 of this act as a condition of their authority to transact insurance business in this State. An insurer shall continue to be deemed an insurer for purposes of this act for a period of four years after the suspension, revocation, nonrenewal or voluntary withdrawal of its license or certificate of authority to transact the business of life, health or annuity insurance in this State.]1

1[6. (New section) a. Within 20 days of the date that a court of competent jurisdiction determines that any health service corporation is insolvent, the Governor shall, with the advice and consent of the Senate, appoint a trustee who shall be a person experienced in insolvency or bankruptcy, and who shall not, during his tenure as trustee, be affiliated with or employed by an insurer or health service corporation. The trustee shall serve at the pleasure of the Governor and shall be paid from monies

available to the fund pursuant to section 7 of this act, in an amount and manner as determined by the commissioner. The trustee shall carry out his powers and duties to fulfill the obligations of the fund as provided for in this act and pursuant to the plan of operation established by the commissioner in accordance with section 9 of this act.

b. Pursuant to the plan of operation, the trustee shall have the authority to disburse monies made available to the fund for the payment of claims arising under covered contracts, and other financial obligations of the fund. The trustee shall prepare a written application for disbursement of any monies from the fund, specifying the amount of the disbursement, the intended expenditures, and the manner in which such expenditures serve the purposes of the trustee's function and this act. The application shall be submitted to the commissioner for approval and, upon such approval, monies from the fund shall be disbursed to the trustee for further disbursement as provided in the approved application.

c. The trustee shall report to the commissioner biannually, or more frequently if ordered by the commissioner, on the financial condition of the insolvent health service corporation and the disbursement of funds pursuant to the plan of operation.

d. In order to fulfill his duties, the trustee shall have the right to avail himself of the services of the department, the insolvent health service corporation and such other persons as may be designated by the commissioner pursuant to the plan of operation.]1

1[7. (New section) a. For the purpose of providing the monies necessary to carry out the obligations of the fund, the trustee shall assess insurers at such time and for such amounts as he finds necessary. Assessments shall be due not less than 30 days after written notice to insurers and shall accrue interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgment, 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 fund which are not objected to by the commissioner. 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 health service corporation to the extent such costs exceed assets of the insolvent health service corporation available for this purpose. Class A assessments need not be related to a particular insolvent health service corporation. The amount of any Class A assessment shall be determined by the trustee.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the trustee with regard to

an insolvent health service corporation. The amount of any Class B assessment shall be allocated for assessment purposes among insurers pursuant to an allocation formula which may be based on the premiums or reserves of the insolvent health service corporation or any other standard deemed by the trustee, with approval by the commissioner, as being fair and reasonable under the circumstances.

c. (1) Class B assessments against any insurer shall be in the proportion that the premiums received on business in this State by an assessed insurer on policies or contracts of life, health and annuity insurance during the four most recent calendar years for which information is available, preceding the year in which the health service corporation became insolvent, bears to such premiums received on business received in this State for such calendar years by all assessed insurers.

(2) Assessments or monies to meet the requirements of the fund with respect to an insolvent health service corporation shall be made as necessary to implement the purposes of the fund. Classification of assessments pursuant to subsection b. of this section and computation of assessments pursuant to this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

d. The trustee shall abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. If an assessment against an 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 insurers in a manner consistent with the basis for assessments set forth in this section and the amount of the abatement or deferral shall become a loan to be repaid by the insurer under terms acceptable to the commissioner.

e. The total of all assessments upon an insurer shall not in any one calendar year exceed two percent of that insurer's average premiums for its life insurance, health insurance and annuity business, as reported in its annual statements in accordance with instructions of the commissioner, received in this State during the four calendar years on which assessments are based pursuant to paragraph (1) of subsection c. of this section. If the maximum assessment does not provide in any one year an amount sufficient to carry out the purposes of the fund, the necessary additional monies shall be assessed as soon thereafter as permitted by this act. The fund's plan of operation may provide a method of allocating available monies among claims when the maximum assessment will be insufficient to cover anticipated claims.

f. The trustee may, by an equitable method as established in the plan of operation, refund to insurers, in proportion to the contribution of each insurer, the amount by which the assets of the fund exceed the amount the trustee, with the concurrence of

the commissioner, finds is necessary to carry out the obligations of the fund, during the coming year, with regard to the insolvency, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in the account to provide funds for the continuing expenses of the fund and for future losses.

g. In determining its premium rates and policyowner dividends as to any kind of insurance subject to the assessment provisions of this act, an insurer may consider the amount reasonably necessary to meet its assessment obligations, except that an insurer shall not use in its calculations that portion of assessments which may be offset against premium taxes pursuant to section 10 of this act.

h. The trustee shall issue to each insurer paying a Class B assessment a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment 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 for such amount and period of time as the commissioner may approve.

i. The fund shall have no cause of action under any assignment pursuant to subsection c. of section 3 of this act which results in any recovery greater than the amount of benefits paid out by the fund. The fund shall have no cause of action against any not-for-profit or nonprofit corporation that is regulated by a law governing the conduct of not-for-profit or nonprofit corporations, except in the event of willful or wanton conduct, unless the not-for-profit or nonprofit corporation is a provider of health care services as defined in section 1 of P.L.1985, c.236 (C.17:48E-1). For purposes of this subsection, "willful or wanton conduct" means a course of action which shows the actual or deliberate intent to cause harm.]1

1[8. (New section) Notwithstanding any other provision of law to the contrary, including, but not limited to, P.L.1975, c.113 (C.17:30C-1 et seq.), and in the event of an insolvency, the assets derived from group contracts, as that term is applicable for the purposes of P.L.1985, c. 236 (C.17:48E-1 et seq.), shall be used to satisfy all liabilities of the group contracts before such assets may be applied to satisfy the liabilities of individual contracts.]1

1[9. (New section) a. Within 60 days of the effective date of this act, the commissioner shall establish a plan of operation necessary and suitable to assure the fair, reasonable and equitable administration of the fund.

b. All insurers shall comply with the plan of operation.

c. The plan of operation shall, in addition to such other requirements as may be deemed necessary:

(1) establish procedures for handling the assets of the fund;

(2) establish procedures for records to be kept of all financial transactions of the fund, its agents, and the trustee;

(3) establish any additional procedures for assessments imposed pursuant to section 7 of this act; and

(4) contain additional provisions necessary or proper for the execution of the powers and duties of the trustee.

d. The plan of operation may provide for the delegation of any or all powers and duties of the trustee to a corporation, association, or other organization which performs or will perform functions similar to those of the trustee. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the trustee and shall be paid for its performance of any function of the trustee. A delegation under this subsection shall take effect only with the approval of 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 pursuant to this act.]1

1 1. (New section) Sections 2 through 19 of this act shall be known and may be cited as the "New Jersey Life and Health Insurance Guaranty Association Act."1

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

b. To provide this protection, an association of insurers is created to pay benefits and to continue coverages, as limited by this act, and members of the association are subject to assessment to provide funds to carry out the purposes of this act.1

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

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

(2) persons who are owners of or certificate holders under those policies or contracts 2, or in the case of unallocated annuity contracts, to the persons who are the contract holders2 and who:

(a) are residents, or

(b) are not residents, but only if:

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

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

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

this act; and

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

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

(1) direct, non-group life, health, annuity and supplemental policies or contracts, for certificates under direct group life, health, annuity and supplemental policies and contracts, 2[and]2 for individual and group long-term care insurance policies and contracts 2, and for unallocated annuity contracts,2 issued by member insurers, except as limited by this act; and

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

c. This act shall not provide coverage for:

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

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

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

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

(i) the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period, or for such lesser period if the policy or contract was issued less than four years before the association became obligated, or

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

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

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

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

(b) a minimum premium group insurance plan;

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

(d) an administrative services only contract;

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

(6) any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue that policy or contract in this State; 2[and]2

(7) any unallocated annuity contract 2issued to an employee benefit plan covered by the Pension Benefit Guaranty Corporation and whose benefits will be paid under such system; and

(8) any portion of any unallocated annuity contract which is not issued to or in connection with a specific plan providing benefits to employees or an association of natural persons2.

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

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

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

(a) 2[$300,000] $500,0002 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(b) 2[$100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values;

(c) $100,000] $500,0002 in present value annuity benefits, including net cash surrender and net cash withdrawal values 2, but not more than $100,000 in net cash surrender and net cash withdrawal values for annuity benefits2;

provided, however, that in no event shall the association be liable to expend more than 2[$300,000] $500,0002 in the aggregate with respect to any one individual under this paragraph (2) 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 benefits2.

e. 2[(1) With respect to health insurance policies or contracts, the association shall pay each individual insured's aggregate claim amount determined in accordance with the terms of the insolvent insurer's policy or contract, less $250, subject to the $100,000 per insured claimant aggregate payment limit specified in subparagraph (b) of paragraph (2) of subsection d. of this

section. If the association's liability associated with a single insured individual's claim exceeds $100,000 the association's payment to providers of health care services shall be prorated. The deductible set forth in this paragraph shall also be prorated among providers. Both prorations shall be based on each provider's percentage of the total expenses associated with the insured which would have been covered under the insolvent insurer's policy or contract.

(2)]2 A provider of health care services, in order to receive payment directly from the association upon a claim of the provider against an insured, shall agree to forgive the insured of 20% of the obligation which would otherwise be paid by the insurer had it not been insolvent. The obligations of solvent insurers to pay all or part of the covered claim are not diminished by the forgiveness provided in this paragraph. The association is not bound by an assignment of benefits executed with respect to the coverage provided by the insolvent insurer. The association may aggregate all claims owed health care providers when negotiating direct payment of claims of all covered individuals 2[and may waive the deductible set forth in paragraph (1) of this subsection when computing the amount owed or to be paid]2.1

14. (New section) As used in this act:

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

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

"Commissioner" means the Commissioner of Insurance.

"Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided under section 3 of this act, but does not include unearned premium under a health insurance policy or contract.

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

"Department" means the Department of Insurance.

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

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

"Member insurer" means any insurer licensed in this State or which holds a certificate of authority to transact any kind of insurance in this State for which coverage is provided under section 3 of this act, and includes any insurer whose license or certificate of authority in this State may have been suspended,

revoked, not renewed or voluntarily withdrawn, but does not include:

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

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

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

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

(5) A mandatory state pooling plan;

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

(7) An insurance exchange; or

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

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

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

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

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

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

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

contracts are not issued to and owned by individuals, except to the extent of any life insurance or health insurance benefits guaranteed to an individual by an insurer under such funding agreement.[1]

[1]5. (New section) a. There is created a nonprofit legal entity to be known as the New Jersey Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this State. Any member insurer shall remain a member insurer for four years after it ceases to hold a certificate of authority or license. The association shall perform its functions under the plan of operation established and approved pursuant to section 9 of this act and shall exercise its powers through the board of directors established under section 6 of this act. The association shall be under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

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

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

(a) life insurance [2][account] subaccount[2]; [2][and][2]

(b) annuity [2][account] subaccount; and

(c) unallocated annuity subaccount[2].

(2) The health insurance account.[1]

[1]6. (New section) a. There shall be a board of directors of the association which shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial members.

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

c. Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors, but members of the board

shall not otherwise be compensated by the association for their services.[1]

[1]7. (New section) a. If a member insurer is an impaired domestic insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not unreasonably impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court ordered receivership, conservation or rehabilitation, also approved by the impaired insurer:

(1) guaranty, assume or reinsure, or cause to be [2][guarantied] guaranteed[2], assumed, or reinsured, any or all of the policies or contracts of the impaired insurer;

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

(3) loan money to the impaired insurer.

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

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

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

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

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

(i) the delinquency proceeding shall not be dismissed,

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

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

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

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

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

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

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

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

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

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

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

(1) (a) guaranty, assume or reinsure, or cause to be [2]guarantied] guaranteed[2], assumed or reinsured, the policies or contracts of the insolvent insurer; or

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

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

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

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

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

(a) with respect to group policies or contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to those policies or contracts;

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

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

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

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

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

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

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

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

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

(6) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be 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.

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

e. When proceeding under subparagraph (b) of paragraph (1) of subsection b. or subsection c. of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest at least equal to that specified in paragraph (3) of subsection c. of section 3 of this act.

f. Nonpayment of premiums within 31 days after the date required, after effective notice shall have been given of the terms of any guarantied, assumed, alternative or reissued policy or contract or substitute coverage, shall terminate the association's obligations under that policy, contract or coverage under this act with respect to that policy, contract or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this act.

g. Premiums due for coverage after entry of an order of

receivership or liquidation of any insolvent insurer shall belong to, and be payable at the direction of, the association.

h. The protection provided by this act shall not apply if any guaranty protection is provided to residents of this State by the law of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

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

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

(2) impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

j. If the association fails to act within a reasonable period of time as provided in subparagraph (b) of paragraph (1) of subsection b. and subsections c. and d. of this section, the commissioner shall have the powers and duties of the association provided by this act with respect to impaired or insolvent insurers.

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

l. The association shall have standing to appear before any court in this State with jurisdiction over an impaired or insolvent insurer with respect to which the association is or may become obligated under this act. That 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 termination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over 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 pursuant to 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 causes of action by any payee, policy or contract owner, beneficiary, insured or annuitant as condition precedent to the receipt of any right or benefits conferred by this act upon that person.

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

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

[2](4) In addition to the rights contained in paragraphs (1), (2) and (3) of this subsection, in the case of any unallocated annuity contract for which benefits are paid by the association under this act, the association shall be deemed to have assigned to it the rights and causes of action of any employee or association of natural persons against the contract holder of such unallocated annuity contract for the amounts paid by the association under this act.[2]

n. The association may:

(1) enter into any contracts 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 imposed pursuant to section 8 of this act and to settle claims or potential claims against it;

(3) borrow money to effectuate 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 persons necessary to handle the financial transactions of the association, and to perform other functions as are necessary or proper under this act;

(5) take any legal action 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 shall 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.[1]

[1]8. (New section) 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 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.

(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 [2][may] shall[2] 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 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.[1]

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

(2) If the association fails to submit a suitable plan of operation within 120 days following the effective date of this act or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt such plan or amendments necessary to effectuate the provisions of this act. The plan or amendments shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

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

c. The plan of operation shall, in addition to requirements enumerated elsewhere in 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 subsection c. of section 6 of this act;

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

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

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

(6) establish any additional procedures for the imposition of assessments under section 8 of this act; and

(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 for the delegation of any or all powers and duties of the association, except those set forth in paragraph (3) of subsection m. of section 7 and section 8 of this

act, to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more other states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection d. shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable or effective than that provided by this act.[1]

[1]10. (New section) a. In addition to the duties and powers enumerated elsewhere in this act, the commissioner shall:

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

(2) when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with a 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 penalty on any member insurer which fails to pay an assessment when due. That penalty shall not exceed five percent of the unpaid assessment per month, but no penalty shall be less than $100 per month.

c. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if that appeal is taken within 30 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 made available to meet association obligations during the pendency of an appeal. If the appeal of an assessment is upheld, the amount paid in error or excess shall be returned to the member 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, conservator or receiver of any impaired insurer may notify all interested persons of the effect of this act.[1]

[1]11. (New section) a. To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner may:

(1) notify the commissioners of insurance or comparable

officials of all the other states, territories of the United States and the District of Columbia when he takes any of the following actions against a member insurer:

(a) revokes its certificate of authority or license;

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

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

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

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

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

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

b. The commissioner may seek the advice and recommendations of the board of directors or member insurers 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 or any member thereof may make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, conservation or receivership of any member insurer or germane to the solvency of any company seeking to do insurance business in this State. Reports and recommendations made pursuant to this subsection 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. Such an examination may be conducted as a NAIC examination or may be conducted by those persons as the commissioner designates. The cost of the examination may 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 of the association prior to its release to the public, but this shall not preclude the commissioner from taking action permitted by subsection a. of this section.

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, if at all, 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 may, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing any information it may have in its possession bearing on the history and causes of that 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 another association.[1]

[1]12. (New section) 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 7 of this act. Records of those negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, conservation or receivership proceeding involving an 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.

c. For the purpose of carrying out its obligations under this act, the association shall be deemed to be a creditor of an impaired or insolvent insurer to the extent of assets attributable to covered policies or contracts reduced by any amounts to which the association is entitled as subrogee pursuant to subsection m. of section 7 of this act. Assets of an impaired or insolvent

insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this act. For purposes of this subsection, assets attributable to covered policies or contracts are that proportion of the assets which the reserves that should have been established for such policies or contracts bears to the reserves that should have been established for all policies or contracts of insurance written by the impaired or insolvent insurer.

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

(2) No dividend or other distribution to stockholders or policyholders of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association for funds expended in carrying out its powers and duties under section 7 of this act with respect to that insurer have been 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 that 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 years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) through (4) of this subsection.

(2) No such distribution shall be recoverable if the insurer shows that the distribution was lawful and reasonable when paid, 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 he 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 he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

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

(5) If any person liable under paragraph (3) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.[1]

[1]13. (New section) The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than 120 days after the close of the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.[1]

[1]14. (New section) 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.[1]

[1]15. (New section) a. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under this act. This immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

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

[1]16. (New section) Upon application and notice, all proceedings in which an insolvent insurer is a party or is obligated to defend a party in any court in this State shall be stayed for 120 days and any additional time thereafter as may be determined by the court from the date the insolvency is determined or any ancillary proceeding is initiated in the State, whichever is later, to permit proper defense by the association of all pending causes of action. With respect to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict or finding set aside by the court in which the judgment, order, decision, verdict or finding is entered and shall be permitted to defend against the claim on the merits.[1]

[1]17. (New section) a. No person, including an insurer, agent or affiliate of an insurer or insurance producer shall make, publish, disseminate, circulate or place before the public or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this act. This subsection shall not apply to the department or the association or to any other entity which does not sell or solicit insurance.

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 which complies with subsection c. of this section. This document shall be submitted to the commissioner for approval. Sixty days after receiving that approval, no insurer may deliver a policy or contract described in subsection b. of section 3 of this act to a policy or contract holder unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract. The document should also be available upon request by a policyholder. The distribution, delivery, contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The document shall be revised by the association as amendments to the act may require. Failure to receive this document does not give the policyholder, contractholder, certificateholder or insured any greater rights than those stated in this act. Delivery of the document required by this subsection shall not be required however, in the case of a policy or contract excluded from coverage under this act pursuant to subsection c. of section 3 of this act and with respect to which notice as required by subsection d. of this section has been given.

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

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

(2) prominently warn the policy or contract holder that the association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this State;

(3) state that the insurer and its insurance producers are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any

form of insurance;

(4) emphasize that the policy or contract holder should not rely on coverage under the association when selecting an insurer; and

(5) provide other information as directed by the commissioner.

d. No insurer or insurance producer may deliver a policy or contract described in subsection b. of section 3 and excluded under paragraph (1) of subsection c. of section 3 from coverage under this act unless the insurer or insurance producer, 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 association. The commissioner may by rule further specify the form and content of the notice.[1]

[1][10.] 18.[1] (New section) a. [1][An] A member[1] insurer [1][assessed pursuant to this act][1] may offset against its premium tax liability, attributable to premiums written in that year, and determined pursuant to section 1 of P.L.1945, c.132 (C.54:18A-1), any assessments for which a certificate of contribution has been issued, pursuant to subsection h. of section [1][7] 8[1] of this act, to the extent of 10% of the amount of those assessments for each of the five calendar years following the [2]second[2] year after the year in which those assessments were paid [2], except that no member insurer may offset its premium tax liability by more than 20% of its premium tax liability in any one year[2]. If [1][an] a member[1] insurer should cease doing business in this State, any uncredited assessments may be offset against its premium tax liability for the year in which it ceases to do business in this State.

b. Any sums which are acquired by [1]member[1] insurers as the result of a refund from the association pursuant to subsection f. of section [1][7] 8[1] of this act, and which have theretofore been offset against premium taxes as provided in subsection a. of this section, shall be paid by those insurers to the State as the Director of the Division of Taxation may require. The [1][trustee] association[1] shall notify the commissioner and the Director of the Division of Taxation of any refunds made.

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

[1]19. (New section) The provisions of sections 2 through 18 of this act shall not apply to any insurer which is insolvent or impaired on December 31, 1990, except as provided in paragraph (2) of subsection b. of section 3 of this act.[1]

[1][11.] 20.[1] Section 6 of P.L.1985, c.236 (C.17:48E-6) is amended to read as follows:

6. The board of a health service corporation which is formed as the result of a merger between a medical service corporation

and a hospital service corporation shall be composed of [32] not more than 15 members. Initially, after the merger has been effected, the board shall be constituted as follows:

a. [Eight] Four members of the board shall be public members, who shall be appointed by the Governor [1]with the advice and consent of the Senate[1]. The public members so appointed shall be persons whose background and experience indicate that they are qualified to act in the broad public interest, who may or may not have coverage under a contract or contracts issued by the corporation, its subsidiaries or affiliates, and who, or whose spouses or minor children, are not officers, directors or owners of more than 10% of the stock of a corporation whose aggregate sales to hospitals, other health care facilities or other providers of health care services exceed 5% of its total sales. [Of the] The remaining eleven members [, seventeen] shall be selected by the board of directors of the [merging hospital service corporation from among its members, and seven shall be selected by the board of directors of the merging medical service corporation from among its members] health service corporation in accordance with the provisions of its certificate of incorporation and bylaws.

b. Of the initial members of the board, as provided for in subsection a. of this section, [two members] one public member [1][appointed by the Governor][1] [, five] and three members [of] selected by the board of the [merging hospital] health service corporation [, and two members of the board of the merging medical service corporation] shall serve for a term of one year; [three members] one public member [1][appointed by the Governor][1] [, five] and three members [of] selected by the board of the [merging hospital] health service corporation [and two members of the board of the merging medical service corporation] shall serve for a term of two years; and [three] two public members [1][appointed by the Governor][1] [, seven] and five members [of] selected by the board of the [merging hospital] health service corporation [and three members of the board of the merging medical service corporation] shall serve for a term of three years. Thereafter, all members of the board shall serve for a term of three years, and shall hold office until their successors are elected and qualified.

c. After the constitution of the initial board as provided in subsection b. of this section, and as the initial terms expire as provided for in that section, the board shall be constituted as follows:

(1) [All of the] Four members shall be public members of the board [shall be] appointed by the Governor [1]with the advice and consent of the Senate[1]; and

(2) [Twenty-four of the] Eleven members shall be elected by the board of directors, as provided in the bylaws.

d. The provisions of subsection c. of this section shall not be

construed to preclude the reappointment or reelection of any member appointed or elected pursuant to subsection a. of this section.

(cf: P.L.1985, c.236, s.6)

[1][12.] 21.[1] Section 7 of P.L.1985, c.236 (C.17:48E-7) is amended to read as follows:

7. The board of directors of a health service corporation which is established in accordance with paragraph (1) of subsection a. of section 2 of [this act] P.L.1985, c.236 (C.17:48E-2) shall have [eight] four public members appointed by the Governor [1]with the advice and consent of the Senate[1] and [24] eleven members elected as provided in the bylaws.

(cf: P.L.1985, c.236, s.7)

[1][13.] 22.[1] Section 5 of P.L.1988, c.71 (C.17:48E-17.1) is amended to read as follows:

5. a. Every health service corporation shall accumulate and maintain during each calendar year two separate special contingent surplus accounts, one for its individual contracts and one for its other activities.

b. Every health service corporation shall accumulate and maintain a special contingent surplus for each account over and above its reserves and liabilities at the rate of 2% annually of its net premium income until that surplus is not less than $1,250,000.00 in each account. The special contingent surplus in each account shall be accumulated to and maintained at an amount not less than 2 1/2% of the net premium income received during that year, as determined by reference to the statement of financial condition filed pursuant to section 36 of P.L.1985, c.236 (C.17:48E-36). The commissioner may increase the minimum amount of special contingent surplus which shall be maintained pursuant to this subsection to an amount not exceeding 5% of the net premium income received during the preceding year. No method of accumulation as herein provided shall be deemed to supersede any provision of subsection c. of this section. In the case of any health service corporation which was created by the merger of a medical service corporation established pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.) and a hospital service corporation created pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), in calculating the proportional allocation of any deficit or surplus between group and individual contracts at the time the separate surplus accounts are created, the corporation shall allocate based on its determination of the proportional contributions of individual and group business to any surplus or deficit during the period between January 1 of the calendar year in which the health service corporation commenced doing business as a health service corporation until the effective date of P.L.1988, c.71. The assumptions upon which the allocations are based shall be certified as reasonable by an independent actuary.

c. Every health service corporation established as of the effective date of P.L.1988, c.71 shall file a recovery plan with the commissioner for meeting the surplus amount requirements established by subsection b. of this section and which establishes a time period within which the corporation will meet those requirements. The time period established in the plan shall not exceed [four] eight years and shall provide for the reduction to 0% of the deficit in the special contingent surplus account for its group and other activities by the end of four years from the effective date of P.L.1988, c.71; and for the reduction to 0% of the special individual contingent surplus account by the end of five years from the effective date of P.L. , c. (now pending in the Legislature as this bill) through the dedication of five approximately equal amounts annually during each year of the five-year period. The commissioner shall take all necessary action to assure that individual rates are actuarially adequate to achieve this purpose. The plan shall be subject to the approval of the commissioner, who shall approve it within 60 days after it has been filed if he believes it to be reasonable. If the commissioner does not approve a plan filed under this subsection within 60 days of its submission, he shall issue findings and conclusions with respect to the reasonableness of the plan.

d. Whenever the special contingent surplus for either group contracts or individual contracts is an amount which is less than 2 1/2% to 5% of the earned premium of the group or individual business, as the case may be, at the discretion of the commissioner, the health service corporation shall, without regard to any other rate increase provided for or required by law or any rate increase which may have previously been taken pursuant to this subsection, and with the approval of the commissioner, commence within 90 days the implementation of rate increases for the group or individual contracts, as the case may be, which increases shall be sufficient to cause the amount of the special contingent surplus to equal an amount which is not less than 5% of the earned premium of the group or individual business within one year of the increase.

e. [In no event shall the] After the end of the recovery plan for the reduction to 0% of the deficit on the individual special contingent surplus account pursuant to subsection c. of this section, a health service corporation, which was created by the merger of a medical service corporation and a hospital service corporation, shall not be required to augment the surplus account allocable to individual contracts with any monies from the surplus account of group contracts, or from any corporate assets or any other source other than net earnings from individual contracts, nor shall it be required to augment the surplus account allocable to group contracts with any monies from the surplus account of individual contracts or from any corporate assets or any other source other than net earnings from group contracts, except that

[beginning with the effective date of P.L.1988, c.71 and until the special contingent surplus account which is applicable to individual contracts has reached the statutorily prescribed amount or no longer than six years following the effective date of P.L.1988, c.71, whichever is earlier, in the event that the statutory reserves of the individual surplus account is in a deficit position, as determined by the commissioner, a loan, without interest, from the group surplus account, if it is not in a deficit position, shall be made to the individual surplus account] the commissioner may require the health service corporation to augment the earnings or surplus account allocable to individual contracts in the amount of any provider differential furnished for this purpose approved by the Hospital Rate Setting Commission pursuant to section 18 of P.L.1971, c.136 (C.26:2H-18).

f. Nothing in this section nor in P.L.1985, c.236 (C.17:48E-1 et seq.) shall abrogate the responsibilities of corporate officers with regard to the reporting of financial condition pursuant to section 36 of P.L.1985, c.236 (C.17:48E-36), nor shall any provision of P.L.1988, c.71 or P.L.1985, c.236 (C.17:48E-1 et seq.) be construed to limit the authority of the commissioner to require compliance with statutory capital, surplus or reserve requirements for a subsidiary or affiliate of a health service corporation, or for any reinsurance activities to be undertaken by a health service corporation.

(cf: P.L.1989, c.295, s.1)

[1][14.] 23.[1] This act shall take effect immediately [1]and sections 1 through 19 shall be retroactive to January 1, 1991[1].

INSURANCE

Extends recovery plan for individual insurance business of health service corporations and establishes guaranty fund for life and health insurers.

pursuant to section 18 of P.L.1971, c.136 (C.26:2H-18).

f. Nothing in this section nor in P.L.1985, c.236 (C.17:48E-1 et seq.) shall abrogate the responsibilities of corporate officers with regard to the reporting of financial condition pursuant to section 36 of P.L.1985, c.236 (C.17:48E-36), nor shall any provision of P.L.1988, c.71 or P.L.1985, c.236 (C.17:48E-1 et seq.) be construed to limit the authority of the commissioner to require compliance with statutory capital, surplus or reserve requirements for a subsidiary or affiliate of a health service corporation, or for any reinsurance activities to be undertaken by a health service corporation.

(cf: P.L.1989, c.295, s.1)

14. This act shall take effect immediately.

STATEMENT

This bill establishes the New Jersey Health Service Corporation Individual Contract Guaranty Fund to protect New Jersey residents and certain non-residents against loss which might occur due to the insolvency of a health service corporation (Blue Cross/Blue Shield of New Jersey). Non-residents of this State are eligible for coverage under the fund only if the insolvent health service corporation is domiciled in this State and never held a license or certificate of authority in the states in which the non-residents reside; the states in which the non-residents reside have life and health guaranty association laws with residency requirements similar to those under this bill; and the non-residents are not eligible for coverage by those associations. The protection under the bill is specifically limited to subscribers and dependents covered under individual and family contracts issued by an insolvent health service corporation. It does not apply to group contracts issued by a health service corporation.

In the event of such insolvency, the Governor is authorized to appoint a trustee, with the advice and consent of the Senate, to pay benefits and continue coverages under covered contracts and levy assessments on commercial insurers in order to provide monies to carry out the purposes of the fund. Liability of the fund is limited to $300,000 in benefits with respect to any one individual. The bill provides for the assignment to the fund of any rights under, and causes of action relating to, a contract covered by the fund. Furthermore, the bill limits causes of action on subrogated claims by the trustee against not-for-profit corporations, with the exception of providers of health care services, to events of willful or wanton conduct.

The fund would be under the supervision of the Commissioner of Insurance and the fund and the trustee thereof would operate pursuant to the provisions of this bill and the plan of operation established by the commissioner so as to provide for the fair,

reasonable and equitable administration of the fund.

The bill provides for two classes of assessments: Class A assessments for administrative and legal costs of the fund and, upon request of the commissioner, the costs incurred by or on behalf of the department in the administration of an insolvent health service corporation to the extent such costs exceed assets of the insolvent health service corporation available for this purpose; and Class B assessments to carry out the powers and duties of the trustee with regard to an insolvent health service corporation. The Class B assessment is levied on commercial insurers and is based on the premiums they received on life, health and annuity business in this State during the four calendar years preceding the assessment while the Class A assessment is to be determined by the trustee. The trustee must abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the commissioner, its payment would endanger the ability of the insurer to fulfill its contractual obligations. The total of all assessments on an insurer must not exceed two percent of that insurer's average premiums received for its life, health and annuity business in this State during the four calendar years preceding the assessment. In determining its premium rates and policy dividends, an insurer so assessed may consider the amount reasonably necessary to meet its assessment obligations, less any amount of assessment to be offset against premium taxes. A certificate of contribution issued by the trustee may be shown by an insurer as an asset on its financial statement for an amount and period of time as the commissioner may approve. The bill provides that an insurer may offset any assessment paid against premium tax at a rate of 10% a year for a period of five years beginning two years after payment of the assessment.

The bill provides that the plan of operation may provide for the delegation of any or all powers and duties of the trustee to a corporation or association which performs or will perform functions similar to those of the trustee. This delegation must be approved by the commissioner.

The bill provides that assets pertaining to the group contracts of an insolvent health service corporation would be used to fulfill the obligations of group contracts and only any excess would be used to cover individual contracts.

The bill also makes certain changes in the composition of the board of directors of a health service corporation by reducing the number of members from 32 to not more than 15. Four are to be public members appointed by the Governor and 11 are to be selected by the health service corporation.

Finally, the bill expands the time period of the recovery plan for the individual side of Blue Cross/Blue Shield's business until five years following the effective date of the bill.

This bill is the same as Senate, No. 3509 [1R], as amended and

reported by the Senate Labor, Industry and Professions Committee on June 17, 1991.

INSURANCE

Establishes New Jersey Health Service Corporation Individual Guaranty Fund.

STATE OF NEW JERSEY
EXECUTIVE DEPARTMENT

July 15, 1991

ASSEMBLY BILL NO. 5051

(FIRST REPRINT)

To the General Assembly:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Assembly Bill No. 5051 (First Reprint) with my objections for reconsideration.

This bill establishes a guaranty fund to pay off policyholders in the event that an insurance company becomes insolvent. I commend the Legislature for the timely passage of this bill and I wholeheartedly support the need for a guaranty fund in New Jersey.

New Jersey is one of the last states without a guaranty fund. Insurance policyholders in New Jersey are in financial danger in the event of an insolvency because their policies may not be worth what they thought. In virtually every other state policyholders are protected by a guaranty fund.

This is a truly important reform and I support most of the provisions in the bill. I believe that, with a few alterations, the bill will vastly improve the climate for life and health insurance in New Jersey.

The improvements I recommend are in two areas. First, I believe the coverage available to policyholders should be increased. Health insurance coverage is limited in the bill to $100,000. I believe health insurance is such a critical necessity in today's society that there should be no artificial limit on what is covered by the guaranty fund. The bill currently provides $300,000 in coverage to life insurance policyholders. I believe that the coverage for life insurance should be increased to $500,000. I also believe individuals who benefit from unallocated annuities, including many who depend on these annuities for their retirement, should be covered.

Second, I believe the creation of a guaranty fund should have minimal impact on taxpayers. The bill currently allows contributing insurance companies to deduct from their premium taxes fifty percent

of any assessment over five years. I recommend that contributing insurance companies be allowed to deduct no more than 20% of their tax liability in any year, and that no deduction will be allowed until an additional year after the assessment is made.

With these changes New Jersey will have a guaranty fund which will protect policyholders. Unfortunately, we are now faced with an unprecedented number of insurance insolvencies, and it is critical that we act to institute a guaranty fund.

Therefore, I herewith return Assembly Bill No. 5051 (First Reprint) and recommend that it be amended as follows:

Page 7, Section 3, Line 38:	After "those policies or contracts" insert ", or in the case of unallocated annuity contracts, to the persons who are the contract holders"
Page 8, Section 3, Line 5:	After "health, annuity and supplemental policies and contracts," delete "and"
Page 8, Section 3, Line 7:	After "contracts" insert ", and for unallocated annuity contracts,"
Page 9, Section 3, Line 10:	After "State;" delete "and"
Page 9, Section 3, Line 11:	After "(7) any unallocated annuity contract" delete "." insert "issued to an employee benefit plan covered by the Pension Benefit Guaranty Corporation and whose benefits will be paid under such system; and"
Page 9, Section 3, After Line 11:	Insert new subsection c. (8) as follows: "(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."
Page 9, Section 3, Line 19:	After "(a)" delete "$300,000" insert "$500,000"
Page 9, Section 3, Lines 22-23:	Delete "(b) $100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values;"
Page 9, Section 3, Line 24:	Delete "(c)" insert "(b)"

Page 9, Section 3, Line 24:	Delete "$100,000" insert "$500,000"
Page 9, Section 3, Line 25:	After "cash surrender and net cash withdrawal values" delete ";" insert ", but not more than $100,000 in net cash surrender and net cash withdrawal values for annuity benefits;"
Page 9, Section 3, Line 27:	After "to expend more than" delete "$300,000" insert "$500,000"
Page 9, Section 3, Line 28:	After "under this paragraph (2)" delete "." insert "; or"
Page 9, Section 3, After Line 28:	Insert new subsections d. (3) and d. (4) as follows: "(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."
Page 9, Section 3, Lines 29-42	After "e." delete "(1) With respect to health insurance policies or contracts, the association shall pay each individual insured's aggregate claim amount determined in accordance with the terms of the insolvent insurer's policy or contract, less $250, subject to the $100,000 per insured claimant aggregate payment limit specified in subparagraph (b) of paragraph (2) of subsection d. of this section. If the association's liability associated with a single insured individual's claim exceeds $100,000, the association's payment to providers of health care services shall be prorated. The deductible set forth in this paragraph shall also be prorated among providers. Both prorations shall be based on each provider's percentage of the total expenses associated with the insured which would have been covered under the insolvent insurer's policy or contract."
Page 9, Section 3, Line 43:	Delete "(2)"
Page 10, Section 3, Line 4:	After "negotiating direct payment of claims of all covered individuals" insert "."

Page 10, Section 3, Lines 5 and 6:	Delete "and may waive the deductible set forth in paragraph (1) of this subsection when computing the amount owed or to be paid."
Page 11, Section 4, Line 20:	After "premiums" insert "in excess of $2,000,000 per contract"
Page 12, Section 5, Line 9:	After "(a) life insurance" delete "account" insert "subaccount"
Page 12, Section 5, Line 9:	After ";" delete "and"
Page 12, Section 5, Line 10:	After "(b) annuity" delete "account." insert "subaccount; and"
Page 12, Section 5, After Line 10:	Insert new subsection b. (1) (c) as follows: "(c) unallocated annuity subaccount."
Page 14, Section 7, Line 40:	Delete "guarantied" insert "guaranteed"
Page 18, Section 7, After Line 1:	Insert new subsection m. (4) as follows: "(4) In addition to the rights contained in paragraphs (1), (2) and (3) of this subsection, in the case of any unallocated annuity contract for which benefits are paid by the association under this act, the association shall be deemed to have assigned to it the rights and causes of action of any employee or association of natural persons against the contract holder of such unallocated annuity contract for the amounts paid by the association under this act."
Page 19, Section 8, Line 32:	After "by which that assessment is exempted, abated or deferred" delete "may" insert "shall"
Page 28, Section 18, Line 2:	After "the five calendar years following the" insert "second"
Page 28, Section 18, Line 3:	After "those assessments were paid" delete "." insert ", except that no member insurer may offset its premium tax liability by more than twenty percent of its premium tax liability in any one year."

STATE OF NEW JERSEY
EXECUTIVE DEPARTMENT

Respectfully,

/s/ James J. Florio

GOVERNOR

[seal]

Attest:

/s/ Elizabeth A. Ryan

Assistant Counsel to the Governor

OFFICE OF THE GOVERNOR
NEWS RELEASE

CN-001
Contact: EMMA BYRNE
NANCY KEARNEY
(609)292-8956

TRENTON, N.J. 08625
Release: Mon., July 15, 1991

STATEMENT OF GOVERNOR JIM FLORIO
on
INSURANCE GUARANTY FUND AND MUTUAL BENEFIT LIFE

"Hardworking men and women who put their savings and their faith into an insurance company shouldn't be left hanging when that company encounters problems. Protection that policyholders can fall back on is an important part of any system that cares about people. Such interests are uppermost in our minds as we prepare to create a guaranty fund in New Jersey, and as we act in regard to the Mutual Benefit Life Insurance Company.

"The state of New Jersey doesn't want to operate insurance companies. That is a job best left to the private sector. But the actions we are taking are required to protect policyholders as well as pension funds.

"I have instructed Insurance Commissioner Sam Fortunato to be vigilant in protecting the interests of policyholders; and to be aggressive in making sure that those who have placed their trust in the company can avoid losses that, through no fault of their own, would be a great burden for them to bear."

* * * * *

The Governor today returned to the Assembly a conditional veto of A-5051, a bill which would establish a guaranty fund to pay off policyholders in the event an insurance company becomes insolvent. The Governor's conditional veto message recommended changes in two areas of the bill -- increasing coverage for policyholders and placing limits on tax deductions for insurance companies which contribute to the guaranty fund.

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*The changes recommended by the Governor include the following:

*Increasing coverage for health insurance benefits to unlimited coverage as opposed to the $100,000 limit in the bill;

*Increasing coverage for life insurance to $500,000 per policyholder as opposed to the $300,000 in the bill;

*Increasing coverage for annuities to $500,000 from the $100,000 in the bill;

*Including coverage for unallocated annuities to the extent these annuities involve benefits for employees or other groups;

*Limiting the tax write-off for insurance companies which pay assessments into the guaranty fund to no more than 20% of their tax liability in any one year;

*Delaying any tax write-off for insurance companies until three years after the assessments are paid.

In his conditional veto message, the Governor noted that New Jersey is one of the last states in the country without a guaranty fund. "Insurance policyholders in New Jersey are in financial danger," said Gov. Florio, "because in the event of an insolvency, their policies may not be worth what they thought."

The Governor added, "This is a truly important reform which I believe, with few alterations, will vastly improve the climate for life and health insurance in New Jersey."

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OFFICE OF THE GOVERNOR
NEWS RELEASE

CN-001
Contact: EMMA BYRNE
NANCY KEARNEY
(609)292-8956

TRENTON, N.J. 08625
Release: Mon., July 15, 1991

A D V I S O R Y

Governor Jim Florio this evening signed into law A-5051Sa, a bill which creates the New Jersey Life and Health Insurance Guaranty Association.

"I am pleased that both houses of the Legislature acted so quickly and responsibly in approving this bill. The unanimous vote by both houses is a sign that this safety net for policyholders, both large and small, was long overdue."

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