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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2020

A N A C T

RELATING TO INSURANCE

Introduced By: Senator Leonidas P. Raptakis

Date Introduced: February 27, 2020

Referred To: Senate Commerce

(Dept. of Business Regulation)

It is enacted by the General Assembly as follows:

SECTION 1. Sections 27-34.3-2, 27-34.3-3, 27-34.3-5, 27-34.3-6, 27-34.3-7, 27-34.3-8 and 27-34.3-9 of the General Laws in Chapter 27-34.3 entitled "Rhode Island Life and Health Insurance Guaranty Association Act" are hereby amended to read as follows:

27-34.3-2. Purpose.

(a) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in § 27-34.3-3(a) against failure in the performance of contractual obligations, under ~~life and~~ health ~~insurance policies~~ and annuity policies, plans, or contracts specified in § 27-34.3-3(b), because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

(b) To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited in this chapter, and members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

(c) In accordance with this purpose, in determining the coverage limits to be applied in § 27-34.3-3 in cases in which there were different statutory limits at the time the insurer was declared impaired and the time the insurer was declared insolvent, the statute with the higher limits shall be applied to the claim.

27-34.3-3. Coverage and limitations.

(a) This chapter shall provide coverage for the policies and contracts specified in subsection (b) of this section:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subsection (2); and

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

(i) Are residents; or

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

(A) The member insurer that issued the policies or contracts is domiciled in this state;

(B) The states in which the persons reside have associations similar to the association created by this chapter; and

(C) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or the health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(3) For unallocated annuity contracts set forth in subsection (b) of this section, paragraphs (1) and (2) of this subsection shall not apply, and this chapter shall (except as provided in paragraphs (5) and (a)(6) of this subsection) provide coverage to:

(i) Persons who are owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(ii) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(4) For structured settlement annuities specified in subsection (b)(1), paragraphs (1) and (2) of this subsection shall not apply, and this chapter shall (except as provided in paragraphs (5) and (6) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

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

(ii) Is not a resident, but only under both of the following conditions:

(A)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident but the insurer that issued the structured settlement annuity is domiciled in this state; and

The state in which the contract owner resides has an association similar to the association created by this chapter; and

(B) Neither the payee or beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(5) This chapter shall not provide coverage to:

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

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

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

(6) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(b)(1) This chapter shall provide coverage to the persons specified in subsection (a) of this section for policies or contracts of direct, non-group life insurance, health insurance (which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates), ~~or annuity policies or contracts~~ annuities and supplemental policies or contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(2) Except as otherwise provided in subsection (3) of this section, this ~~This~~ chapter shall not provide coverage for:

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

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's corporate bond yield average averaged for that same four-year (4) period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:

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

(B) A minimum premium group insurance plan;

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

(D) An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract.

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) A portion of unallocated annuity contract that is not issued to or in connection with a

specific employee, union or association of natural persons benefit plan or a government lottery;

(ix) A portion of a policy or contract to the extent that the assessments required by § 27-34.3-9 with respect to the policy or contract are preempted by federal or state law; and

(x) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including, without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) Misrepresentations of or regarding policy or contract benefits;

(D) Extracontractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(xi) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(xii) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then, for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(xiii) Any transaction or combination of transactions between a protected cell and the general account or another protected cell of a protected cell company organized under chapter 64 of this title; ~~or~~

(xiv) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of subchapter XVIII, chapter 7 of title 42 of the United States Code (commonly known as Medicare part C & D), or Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto; or

(xvii) Structured settlement annuity benefits to which a payee (or beneficiary) has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(3) The exclusion from coverage referenced in subsection (2)(iii) of this section shall not apply to any portion of a policy or contract, including a rider, that provides a long-term care or any other health insurance benefits.

(c) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

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

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

(A) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;

(B) ~~In~~ For health insurance benefits:

(I) One hundred thousand dollars ($100,000) for coverages not considered as disability income insurance or ~~basic hospital, medical and surgical insurance or major medical insurance~~ health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(II) Three hundred thousand dollars ($300,000) for disability income insurance and three hundred thousand dollars ($300,000) for long-term care insurance;

(III) Five hundred thousand dollars ($500,000) for health benefit plans ~~basic hospital, medical and surgical insurance~~; or

(C) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) With respect to each individual participating in a governmental retirement plan established under § 401, 403(b) or 457 of the U.S. Internal Revenue Code, 26 U.S.C. § 401, 403(b) or 457, covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) With respect to each payee of a structured settlement annuity or beneficiary or beneficiaries, of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal

values if any;

(iv) However in no event shall the association be obligated to cover more than: (A) an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one life under this paragraph and paragraphs (i), (ii) and (iii) of this subdivision except with respect to benefits for health benefit plans ~~basic hospital, medical and surgical insurance and major medical insurance~~ under subparagraph 2(i)(B) of this subsection, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars ($500,000) with respect to any one individual; or (B) with respect to one owner of multiple non-group policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner;

(v) With respect to either: (A) one contract owner provided coverage under subsection (a)(3)(i); or (B) one plan sponsor whose plans own directly or in trust any one or more unallocated annuity contracts not included in paragraph (ii) of this subdivision, five million dollars ($5,000,000) in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. Provided, however, in the case where one or more unallocated annuity contracts that are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two (2) or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than five million dollars ($5,000,000) in benefits with respect to all such unallocated contracts;

(vi) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(vii) For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(d) In performing its obligations to provide coverage under § 27-34.3-8, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, contractual obligations of the insolvent or impaired

insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

27-34.3-5. Definitions.

As used in this chapter:

(1) "Account" means either of the two accounts created under § 27-34.3-6.

(2) "Association" means the Rhode Island life and health insurance guaranty association created under § 27-34.3-6.

(3) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(5) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) "Commissioner" means ~~the commissioner of insurance within the department of business regulation of this state~~ the definition prescribed by § 42-14-5.

(7) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion of a group policy or contract for which coverage is provided under § 27-34.3-3.

(8) "Covered contract or covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided under § 27-34.3-3.

(9) "Extra-contractual claims" means claims not arising directly out of contract provisions, including, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs.

(10) “Health benefit plan” means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. “Health benefit plan” does not include:

(i) Accident only insurance:

(ii) Credit insurance;

(iii) Dental only insurance;

(iv) Vision only insurance;

(v) Medicare Supplement insurance;

(vi) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(vii) Disability income insurance;

(viii) Coverage for on-side medical clinics; or

(ix) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

~~(10)~~(11) "Impaired insurer" means a member insurer which is not an insolvent insurer, and

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

~~(11)~~(12) "Insolvent insurer" means a member insurer which after January 1, 1996, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

~~(12)~~(13) "Member insurer" means any insurer or health maintenance organization licensed or which holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under § 27-34.3-3, and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(i) A hospital or medical service organization, whether profit or nonprofit; or

(ii) ~~A health maintenance organization; or~~

(iii) A fraternal benefit society; or

(iv) A mandatory state pooling plan; or

(v) A mutual assessment company or other person that operates on an assessment basis; or

(vi) An insurance exchange; or

(vii) An organization that has a certificate or license limited to the issuance of charitable gift annuities; or

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

~~(13)~~(14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor to it.

~~(14)~~(15) "Owner" of a policy or contract, "policyholder", ~~and~~ "policy owner" ~~and~~ or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder

and policy owner do not include persons with a mere beneficial interest in a policy or contract.

~~(15)~~(16) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

~~(16)~~(17) "Plan sponsor" means:

(i) The employer in case of a benefit plan established or maintained by a single employer;

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

(iii) In the case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

~~(17)~~(18) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits, and less dividends and experience credits. "Premiums" does not include any amounts or consideration received for any policies or contracts or for the portions of policies or contracts for which coverage is not provided under § 27-34.3-3(b) except that assessable premium shall not be reduced on account of § 27-34.3-3(b)(2)(iii) relating to interest limitations and § 27-34.3-3(c)(2) relating to limitations with respect to one individual, one participant and one owner. "Premiums" shall not include:

(i) Premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under § 401, 403(b) or 457 of the United States Internal Revenue Code, 26 U.S.C. § 401, 403(b) or 457.

(ii) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

~~(18)~~(19)(i) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(A) The state in which the primary executive and administrative headquarters of the entity is located;

(B) The state in which the principal office of the chief executive officer of the entity is

located;

(C) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(D) The state in which the executive or management committee of the board of directors (or a similar governing person or persons) of the entity, conducts the majority of its meetings;

(E) The state from which the management of the overall operations of the entity is directed; and

(F) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(ii) The principal place of business of a plan sponsor of a benefit plan described in subsection ~~(16)~~(17)(iii) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

~~(19)~~(20) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer.

~~(20)~~(21) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of court order that determines a member insurer to be an impaired insurer or a court order that determines a member insured to be an insolvent insurer, whichever occurs first. 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. Citizens of the United States that are either: (i) residents of foreign countries; or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this chapter, shall be deemed residents of the state of domicile of the member insurer that issued the polices or contracts.

~~(21)~~(22) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a claimant in payment for or with respect to personal injuries suffered by the claimant.

~~(22)~~(23) "State" means a state, the District of Columbia, Puerto Rico, or a United States possession, territory or protectorate.

~~(23)~~(24) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

~~(24)~~(25) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

27-34.3-6. Creation of the association.

(a) There is created a nonprofit legal entity to be known as the Rhode Island 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 or health management organization business in this state. The association shall perform its functions under the plan of operation established and approved under § 27-34.3-10, or as previously established and approved under § 27-34.1-11 [Repealed] and shall exercise its powers through a board of directors established under § 27-34.3-7 or as previously established under § 27-34.1-8 [Repealed] For purposes of administration and assessment, the association shall maintain two (2) accounts:

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

(i) Life insurance account;

(ii) Annuity account; which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under section 401, 403(b) or 457 of the United States Internal Revenue Code, 26 U.S.C. § 401, 403(b) or 457, but shall otherwise exclude unallocated annuities; and

(iii) Unallocated annuity account which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under § 401, 403(b) or 457 of the United States Internal Revenue Code, 26 U.S.C. § 401, 403(b) or 457.

(2) The health ~~insurance~~ account.

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be open to the public upon majority vote of the board of directors. The commissioner or his or her designee shall have full and complete access to all documents received by, created by or otherwise obtained by the association and shall be invited to be present at all association meetings. The disclosure of confidential or privileged association information, documents, or records to the commissioner shall not change the confidential or privileged status of the information, documents or records.

27-34.3-7. Board of directors.

(a) The board of directors of the association shall consist of:

(1) Not less than ~~five (5)~~ seven (7) nor more than ~~nine (9)~~ (eleven (11) member insurers serving terms as established in the plan of operation; and

(2) The commissioner or the commissioner's designee. Only member insurers or a health maintenance organization shall be eligible to vote. The members of the board shall be selected by member insurers subject to the approval of the commissioner. The board of directors, previously established under § 27-34.1-8 [Repealed], shall continue to operate in accordance with the provision of this section. 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.

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

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not be compensated by the association for their services.

27-34.3-8. Powers and duties of the association.

(a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner:

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

(2) Provide the monies, pledges, loans, notes, guarantees or other means that are proper to effectuate subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection.

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

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

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

(ii) Provide monies, pledges, loans, notes, guarantees, or other means that are reasonably necessary to discharge the association's duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to policies and contracts ~~life and health insurance policies and annuities,~~ 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 insolvent insurer, for claims incurred:

(A) With respect to group policies and contracts, not later than the earlier of the next

renewal date under such policies or contracts or forty-five (45) days, but in no event less than thirty (30) days after the date on which the association becomes obligated with respect to the policies or contracts;

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

(ii) Make diligent efforts to provide all known ~~insured~~ insureds, enrollees or annuitants (for non-group policies and contracts) or group policy or contract owners with respect to group policies or contracts thirty (30) days notice of the termination (pursuant to subparagraph (i) of this paragraph) of the benefits provided;

(iii) With respect to nongroup policies and contracts ~~life and health insurance policies and annuities~~ covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, or annuitant and with respect to an individual formerly an insured, enrollee or ~~formerly an~~ annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (iv) of this subsection, if the insureds, enrollees or annuitants had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy or contract or annuity or had a right only to make changes in premium by class;

(iv)(A) In providing the substitute coverage required under subdivision (iii) of this subsection, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates subject to the prior approval of the commissioner.

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

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

(v)(A) Alternative policies adopted by the association shall be subject to the approval of the ~~domiciliary insurance~~ commissioner ~~and the receivership court~~. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(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. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(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.

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

(vii) 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 such coverage or policy or contract is replaced by another similar policy or contract by the policy owner, the insured, the enrollee or the association.

(viii) When proceeding under paragraph (b)(2) 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 consistent with § 27-34.3-3(b)(2)(iii).

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

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

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

(f) In carrying out its duties under subsection (b), the association may:

(1) Subject to approval by a court of competent jurisdiction in this state, impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(2) Subject to approval by a court of competent jurisdiction in this state, 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. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of such cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(g) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of ~~an~~ a member insurer domiciled in this state or in a reciprocal state, pursuant to § 27-14.3-56, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amounts so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state insurance law dealing with early access disbursements.

(h) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (b) of this section, the commissioner shall have the powers and duties of the association under this chapter with respect to the insolvent insurers.

(i) The association may render assistance and advice to the commissioner, upon the

commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(j) The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the polices or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(k)(1) A person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverage. The association may require an assignment to it of these rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the 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 chapter.

(3) In addition to subdivisions (1) and (2) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee, of a policy or contract with respect to the policy or contracts including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under § 130 of the United States Internal Revenue Code, 26 U.S.C. § 130.

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

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

(l) In addition to the rights and powers provided in this chapter, the association may:

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

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 27-34.3-9 and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this chapter; 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 as are necessary or appropriate to handle the financial transactions of the association, and to perform any other functions as become necessary or proper under this chapter;

(5) Take such legal action that may be necessary or appropriate to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life insurer, ~~or~~ health insurer, or health maintenance organization, but in no case may the association issue ~~insurance~~ policies or ~~annuity~~ contracts other than those issued to perform its obligations under this chapter;

(7) Organize itself as a corporation or another legal form permitted by the laws of this state;

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; ~~and~~

(9) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this act; and

~~(9)~~(10) Take other necessary or appropriate action to discharge its duties and obligations

under this chapter or to exercise its powers under this chapter.

(m) 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.

(n)(1)(a) At any time within one hundred eighty (180) days of the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the association or the national organization of life and health insurance guaranty associations (NOLHGA) on its behalf sending written notice, return receipt requested to the affected reinsurers.

(b) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings: (i) Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and (ii) Notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(c) The following subparagraphs (i) through (iv) shall apply to reinsurance contracts so assumed by the association.

(i) The association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts and annuities covered, in whole or in part, by the association. The association may charge policies, contracts and annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

(ii) The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered in whole or in part, by the association provided, that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were

paid a portion of the amount equal to the lesser of:

(A) The amount received by the association; or

(B) The excess of the amount received by the association; over the amount equal to the benefits paid by the association on account of the policy, contract or annuity less the retention of the insurer applicable to the loss or event;

(iii) Within thirty (30) days following the association's election (the "election date"), the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each such reinsurance contract as of the election date with respect to policies, contracts or annuities covered, in whole or in part, by the association which calculation shall give, full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining premiums in each case within five (5) days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association pursuant to paragraph (ii), the receiver, shall remit the same to the association as promptly as practicable.

(iv) If the association or receiver, on the association's behalf, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date, that relate to policies, contracts or annuities covered in whole or in part by the association the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered in whole or in part by the association and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association against amounts due to the association.

(2) During the period from the date of the order of liquidation until the election date (or, if the election date does not occur, until one hundred eighty (180) days after the date of the order of liquidation).

(a)(i) Neither the association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the association has the right to assume under subdivision (n)(1), whether for periods prior to or after the date of the order of liquation; and

(ii) The reinsurer, the receiver and the association shall, to the extent practicable, provide each other data and records reasonably requested;

(b) Provided that once the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by subdivision (n)(1).

(3) If the association does not elect to assume a reinsurance contract by the election date pursuant to subdivision (n)(1), the association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(4) When policies, contracts or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts or annuities may also be transferred by the association, in the case of contracts assumed under subdivision (n)(1), subject to the following:

(a) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

(b) The obligations described in paragraph (n)(1) of this section shall not apply with respect to matters arising after the effective date of the transfer;

(c) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

(5) The provisions of subsection (n) shall supersede the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation to the receiver, of the insolvent insurer or any other person. The receiver, shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation subject to applicable setoff provisions.

(6) Except as otherwise provided in this section, nothing in this section (n):

Shall alter or modify the terms and conditions of any reinsurance contract.

Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract.

Nothing in this section shall give a policy holder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section shall limit or affect the association's rights as a creditor of the estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks.

(o) The board of directors of the association shall have discretion and shall exercise

reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(p) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(q) Venue in a suit against the association arising under this chapter shall be in Providence County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

~~(q)~~(r) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection (a) or (b) of this section, the association may, ~~subject to approval of the receivership court,~~ issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

~~(r) Venue in a suit against the association arising under this chapter shall be in Providence County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.~~

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(i) A fixed interest rate; or

(ii) Payment of dividends with minimum guarantees; or

(iii) A different method of calculating interest or changes in value.

(2) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

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

27-34.3-9. Assessments.

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at nine percent (9%) per annum on and after the due date.

(b) There shall be two (2) classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under § 27-34.3-8 with regard to an impaired or an insolvent insurer.

(c)(1) The amount of any Class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The total of all non-pro rata assessment shall not exceed three hundred dollars ($300) per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) The amount of a Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(3) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the Plan of Operation and approved by the commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

~~(2)~~(4) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer or policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became insolvent, (or, in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired) bears to premiums received on business in this state for such calendar years by all assessed member insurers.

~~(3)~~(5) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the

purposes of this chapter. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions which have caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e)(1)(i) Subject to the provisions of subparagraph (ii) of this paragraph, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in any one calendar year exceed three percent (3%) of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(ii) If two (2) or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subparagraph (i) of this paragraph shall be equal and limited to the higher of the three (3) year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(iii) 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 after this as permitted by this chapter.

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

(3) If the maximum assessment for a subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision (c)(2) of this section, the board shall assess the other subaccounts of the

life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (1) of this subsection.

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

(g) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(h) The association shall issue to each insurer paying an assessment under this chapter, other than Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(i)(1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

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

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

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

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE

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This act would bring the Rhode Island Life and Health Insurance Guaranty Fund statute into conformance with the latest version of the National Association of Insurance Commissioners Model Act.

This act would take effect upon passage.

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