SPONSOR: Sen. Paradee & Rep. Bush

DELAWARE STATE SENATE
150th GENERAL ASSEMBLY

SENATE BILL NO. 132

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 4402, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4402. Purpose.

The purpose of this chapter is to protect, subject to certain limitations, the persons specified in § 4403(a) of this title against failure in the performance of contractual obligations, under ~~life and health insurance policies~~ life, health, and annuity policies, plans, or contracts specified in § 4403(b) of this title, because of the impairment or insolvency of the member insurer that issued the ~~policies~~ policies, plans, or contracts. To provide this protection, an association of member insurers is created to pay benefits and to continue coverage as limited ~~herein~~ in this chapter, and members of the Association are subject to assessment to provide funds to carry out the purpose of this chapter.

Section 2. Amend § 4403, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4403. 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~~ assignees, or ~~payees~~ payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under paragraph (a)(2) of this section;

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

a. Are residents; or

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

1. The member insurer which issued such policies or contracts is domiciled in this State;

2. The states in which the persons reside have associations similar to the Association created by this chapter;

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

(5) This chapter shall not provide coverage to:

a. 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~~

b. A person covered under paragraph (a)(3) of this section if any coverage is provided by the association of another state to the ~~person.~~ person; or

c. 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 26 U.S.C. § 5891(c)(3)(A) 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 1 state, whether as an owner, payee, enrollee,~~beneficiary~~ 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, nongroup ~~life,~~ life insurance; health insurance, which for the purposes of this chapter includes managed care organization and health maintenance organization subscriber contracts and certificates; or ~~annuity policies or contracts and supplemental contracts to any of these,~~ annuities for certificates under direct group policies and contracts, and for supplemental contracts to any of these, and for unallocated annuity ~~contracts~~ contracts, in each case issued by member ~~insurers~~ 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, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

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

a. Any portion of a policy or contract not guaranteed by the member insurer or under which the risk is borne by the policy or contract owner;

d. Any 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 such plan or program is self-funded or uninsured, including ~~but not limited to~~ benefits payable by an employer, ~~association~~ association, or other person under any of the following:

1. A multiple employer welfare ~~arrangement~~ arrangement, as defined in ~~29 U.S.C. § 1144;~~ Section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002(40));

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

j. 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~~ owner, or policy owner, ~~including without limitation.~~ including:

1. Claims based on marketing materials;

2. 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;

3. Misrepresentations of or regarding policy or contract benefits;

4. Extracontractual claims; or

5. A claim for penalties or consequential or incidental damages; and

l. 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 ~~(b)(2)a.~~ (b)(2)l. of this section, 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.

m. Any employer owned life insurance policy, as defined in § 2704(e) of this title.

n. A policy or contract providing any hospital, medical, prescription ~~drug~~ drug, or other health-care benefits ~~pursuant to~~ under Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the U.S.C. (commonly known as Medicare ~~Part C and D) or~~ Part C and D); Subchapter XIX, Chapter 7 of Title 42 of the U.S.C. (commonly known as Medicaid); or any regulations issued ~~pursuant thereto.~~ under either of these provisions.

o. Structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's 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 26 U.S.C. § 5891(c)(3)(A) became effective.

(3) The exclusion from coverage under paragraph (2)c. of this section does not apply to any portion of a policy or contract, including rider, that provides 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 the following:

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

1. $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

2. ~~In~~ For health insurance benefits:

A. $100,000 for coverages not defined as disability income~~insurance or~~ insurance, health benefit plans, or long-term care insurance ~~basic hospital, medical and surgical insurance or major medical insurance~~ including any net cash surrender and net cash withdrawal values;

B. $300,000 for disability income insurance and $300,000 for long-term care insurance. For purposes of this section, "disability income insurance" ~~shall mean~~ means the type of policy which pays a monthly or weekly amount if an individual is disabled and cannot work. "Long-term care insurance" ~~shall have the meaning~~ means as defined in § 7103(5) of this ~~title.~~title;

C. $500,000 for ~~basic hospital, medical and surgical insurance or major medical insurance For purposes of this section "basic hospital, medical and surgical insurance" shall mean a policy which pays a certain portion of hospital room and board costs each day. This type of policy also pays for hospital~~

~~services and supplies such as x-rays, lab tests, medicine and other items up to a stated amount. "Major medical insurance" shall mean health insurance to finance the expense of major illness and injury characterized by large benefits maximums. This type of insurance reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs and medicines above an initial deductible. The insured person as coinsurer pays the remainder; or~~ health benefit plans; or

3. $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values.

b. With respect to each individual participating in a governmental retirement benefit 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, $250,000 in the aggregate in present value annuity benefits, including net cash surrender and net cash withdrawal values;

c. With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee, if deceased), $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

d. However, in no event shall the Association be obligated to cover more than (i) an aggregate of $300,000 in benefits with respect to any 1 life under paragraphs (c)(2)a., ~~(c)(2)b.~~ (c)(2)b., and (c)(2)c. of this section except with respect to benefits for ~~basic hospital, medical and surgical insurance and major medical insurance~~ health benefit plans under paragraph (c)(2)a.2. of this section, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any 1 individual; or (ii) with respect to 1 owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, ~~corporation~~ corporation, or other person, and whether the persons insured are officers, managers, ~~employees~~ employees, or other persons, more than $1,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

f. 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.

g. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract are 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 § 4408 of this title, the Association shall not be required to guarantee, assume, ~~reinsure~~ reinsure, reissue, or perform, or cause to be guaranteed, assumed, ~~reinsured~~ reinsured, reissued, or performed, the 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.

Section 3. Amend § 4405, Title 18 of the Delaware Code by making deletions as shown by strike through, insertions as shown by underline and by redesignating accordingly:

§ 4405. Definitions.

As used in this chapter:

(8) "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under § 4403 of this title.

(9) "Extracontractual claims" ~~shall include, for example,~~ includes 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, managed care organization or health maintenance organization subscriber contract, or any other similar health contract. "Health benefit plan" does not include any of the following:

a. Accident only insurance.

b. Credit insurance.

c. Dental insurance.

d. Vision only insurance.

e. Medicare Supplement insurance.

f. Benefits for long-term care, home health care, community-based care, or any combination thereof.

g. Disability income insurance.

h. Coverage for on-site medical clinics.

i. 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.

~~(12)~~ (13) "Member insurer" means an ~~insurer~~ insurer, managed care organization, or health maintenance organization licensed or that holds a certificate of authority to transact in this State any kind of ~~insurance~~ insurance,

managed care organization, or health maintenance organization business for which coverage is provided under § 4403 of this title, and includes an ~~insurer~~ insurer, managed care organization, 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:

a. A hospital or medical service organization, whether profit or nonprofit;

b.~~A health maintenance organization;~~ [Repealed.]

c. A fraternal benefit society;

d. A mandatory state pooling plan;

e. A mutual assessment company or other person that operates on an assessment basis;

f. An insurance exchange;

g. An organization which has a certificate or license limited to the issuance of charitable gift annuities; or

h. An entity similar to any of the above.

~~(14)~~ (15) "Owner" of a policy or contract and "policyholder", "policy ~~owner"~~ owner", and "contract owner" mean 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~~ owner, policyholder, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

~~(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 amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under § 4403(b) of this title except that assessable premium shall not be reduced on account of § 4403(b)(2)c. of this title relating to interest limitations and § 4403(c)(2) of this title relating to limitations with respect to 1 individual, 1 ~~participant~~ participant, and 1 policy or contract owner. "Premiums" ~~shall~~ does not include:

a. Premiums in excess of $1,000,000 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], or

b. With respect to multiple nongroup policies of life insurance owned by 1 owner, whether the policy or contract owner is an individual, firm, ~~corporation~~ corporation, or other person, and whether the persons insured are

officers, managers, ~~employees~~ employees, or other persons, premiums in excess of $1,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

~~(18)~~ (19)a. "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:

1. The state in which the primary executive and administrative headquarters of the entity is located;

2. The state in which the principal office of the chief executive officer of the entity is located;

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

4. The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meeting;

5. The state from which the management of the overall operations of the entity is directed; and

6. 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 50 percent 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.

b. The principal place of business of a plan sponsor of a benefit plan described in ~~paragraph (16)c.~~ paragraph (17)c. 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) "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) "Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent ~~insurer, whichever occurs first.~~ insurer. A person may be a resident of only 1 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 policies or contracts.

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

Section 4. Amend § 4406, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4406. Delaware Life and Health Insurance Guaranty Association — Created; accounts; supervision.

(a) There is created a nonprofit legal entity to be known as the Delaware 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~~ insurance, managed care organization, or health maintenance organization business in this State. The Association shall perform its functions under the plan of operation established and approved under § 4410 of this title, and shall exercise its powers through a Board of Directors established under § 4407 of this title. For purposes of administration and assessment, the Association shall maintain 2 accounts:

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

a. Life insurance account;

b. Annuity account, which shall include annuity contracts owned by a governmental retirement 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], but shall otherwise exclude unallocated annuities; and

c. 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.

Section 5. Amend § 4408, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4408. 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~~ 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; or

(2) Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a)(1) of this section and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a)(1) of this section.

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

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

2. Assure payment of the contractual obligations of the insolvent insurer; and

b. Provide moneys, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the Association's duties; or

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

a. With respect to ~~life and health insurance policies and annuities,~~ policies and contracts, assure payment of benefits ~~for premiums identical to the premiums and benefits (except for terms of conversation and renewability)~~ that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and 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 the policies and contracts;

2. 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 1 year, but in no event less than 30 days from the date on which the Association becomes obligated with respect to the policies or contracts;

b. Make diligent efforts to provide all known ~~insureds~~ insureds, enrollees, or annuitants (for nongroup policies and contracts), or group policy or contract owners with respect to group policies and contracts, 30 days' notice of the ~~termination (pursuant to~~ termination, under paragraph (b)(2)a. of this ~~section)~~ section, of the benefits provided;

c. With respect to nongroup ~~life and health insurance policies and annuities~~ policies and contracts covered by the Association, make available to each known ~~insured~~ insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly ~~insured~~ 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 paragraph (b)(2)d. of this section, if the ~~insureds~~ insureds, enrollees, or annuitants had a right under law or the terminated ~~policy~~ policy, contract, or annuity to convert coverage to individual coverage or to continue an individual ~~policy~~ policy, contract, or annuity in force until a specified age or for a specified time during which the ~~insurer~~ insurer, managed care organization, or health maintenance organization had no right unilaterally to make changes in any provision of the ~~policy~~ policy, contract, or annuity or had a right only to make changes in premium by class;

(3)a. In providing the substitute coverage required under paragraph (b)(2)c. of this section, the Association may offer either to reissue the terminated coverage or to issue an alternative ~~policy.~~ policy or contract at actuarially justified rates.

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

c. The Association may reinsure any alternative or reissued ~~policy.~~ policy or contract.

(4)a. Alternative policies or contracts adopted by the Association shall be subject to the approval of the ~~domiciliary insurance commissioner and the receivership court.~~ Commissioner. 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 that 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.

(5) If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated ~~policy,~~ policy or contract, the premium shall be actuarially justified and set by the Association in

accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the ~~domiciliary insurance commissioner and the receivership court.~~ Commissioner.

(6) 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 the ~~coverage or policy~~ coverage, policy, or contract is replaced by another similar policy or contract by the policy or contract owner, the ~~insured~~ insured, the enrollee, or the Association.

(7) When proceeding under paragraph (b)(2) of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with § 4403(b)(2)c. of this title.

(c) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, ~~alternative~~ alternative, or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the ~~policy~~ policy, contract, or coverage under this chapter with respect to the ~~policy~~ policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due ~~in accordance with~~ under this chapter.

(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, shall be promptly paid to the Association. The Association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in 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~~ under § 5911 of this title or similar provision of the state of domicile of the impaired or insolvent insurer.

(j) The Association shall have standing to appear or intervene before a 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 which 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,~~ including proposals for reinsuring, ~~modifying~~ reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The

Association shall also have the right to appear or intervene before a court 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~~ coverage, or provision of substitute or alternative policies, contracts, or coverages. The Association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, ~~insured~~ 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 paragraphs (k)(1) and (2) of this section, 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~~ beneficiary, enrollee, or payee of a policy or contract with respect to the policy or ~~contracts (including without limitation,~~ contracts, including 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~~ under this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code § 130 [26 U.S.C. ~~§ 130]).~~ § 130].

(4) If ~~the preceding provisions~~ paragraphs (k)(1) through (k)(3) 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)~~ 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 as to which the Association has rights as described in ~~the preceding paragraphs~~ paragraphs (k)(1) through (k)(4) of this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts, ~~(or portion thereof)~~ or portion thereof, covered by the Association.

(*l*) In addition to the rights and powers elsewhere in this chapter, the Association may:

(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 member insurers and may be carried as admitted assets;

(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;~~ insurer, managed care organization, 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 in other legal form permitted by the laws of ~~the~~ 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 chapter; 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.

(n)(1) At any time within 180 days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to ~~policies~~ policies, contracts, or annuities ~~covered (in whole or in part)~~ covered, in whole or part, by the Association, in each case under any 1 or more reinsurance contract or 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.

(2) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance and 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:

a. 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

b. 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.

(3) The following paragraphs (n)(3)a. through f. of this section shall apply to reinsurance contracts so assumed by the Association:

a. 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~~ policies, contracts, or annuities ~~covered (in whole or in part)~~ covered, in whole or part, by the Association. The Association may charge ~~policies~~ policies, contracts, or annuities covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator.

b. The Association shall be entitled to any and all 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~~ policies, contracts, or annuities ~~covered (in whole or in part)~~ covered, in whole or part, by the Association, ~~provided that,~~ if, upon receipt of any such amounts the Association shall be obligated to pay to the beneficiary under the ~~policy~~ policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

1. The amount received by the Association; and

2. The excess of the amount received by the Association, over the amount equal to the benefits paid by the Association on account of the ~~policy~~ policy, contract, or annuity less the retention of the insurer applicable to the loss or event.

c. Within 30 days following the Association's election (the "election date"), the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to ~~policies~~ 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~~ before the election date. The reinsurer shall pay the receiver any amounts due for losses or events ~~prior to~~ before the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within 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~~

under 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~~ under paragraph (n)(3)b. of this section, the receiver shall remit the same to the Association as promptly as practicable.

d.1. If the Association or the receiver, on the Associations' behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to ~~policies~~ policies, contracts, or annuities ~~covered (in whole or in part)~~ covered, in whole or part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay a premium insofar as the reinsurance contracts relate to ~~policies~~ policies, contracts, or annuities covered, in whole or ~~in~~ part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

2. During the period from the date of the order of liquidation until the election ~~date (or,~~ date, or, if the election date does not occur, until 180 days after the date of the order of ~~liquidation).~~ 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 paragraph (n)(1) of this section, whether for periods ~~prior to~~ before or after the date of the order of liquidation; and

II. The reinsurer, the ~~receiver~~ 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 paragraph (n)(1) of this section.

3. If the Association does not elect to assume a reinsurance contract by the election date ~~pursuant to~~ under paragraph (n)(1) of this section, 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~~ policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the ~~policies~~ policies, contracts, or annuities may also be transferred by the Association, in the case of contracts assumed under paragraph (n)(1) of this section, subject to the following:

A. Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract that is transferred shall not cover any new policies of ~~insurance~~ insurance, contracts, or annuities in addition to those transferred;

B. The obligations described in paragraph (n)(3)d.1. of this section shall no longer apply with respect to matters arising after the effective date of the transfer; and

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

e. The provisions of this 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~~ before the date of the order of liquidation, subject to applicable setoff provisions.

f. Except as otherwise provided in this section, nothing in this subsection (n) shall:

1. Alter or modify the terms and conditions of any reinsurance contract;

2. Abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract;

3. Provide a ~~policyholder~~ policyholder, contract owner, enrollee, certificate holder, or beneficiary with an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

4. Limit or affect the Association's rights as a creditor of the estate against the assets of the estate;

5. Apply to reinsurance agreements covering property or casualty risks.

(r) In carrying out its duties in connection with guaranteeing, ~~assuming~~ 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,~~ may issue substitute coverage for a policy or contract that provides an interest rate, crediting ~~rate~~ rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

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

a. A fixed interest rate; or

b. Payment of dividends with minimum guarantees; or

c. A different method for calculating interest or changes in value;

(2) There is no requirement for evidence of insurability, waiting ~~period~~ 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 materials terms.

Section 6. Amend § 4409, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4409. Assessments.

(c)(1)a. 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 C assessments. ~~The total of all non-pro rata assessments shall not exceed $300 per member insurer in any 1 calendar year.~~

b. The amount of class C ~~assessment~~ assessment, except for assessments relating to long-term care insurance, shall be allocated for assessment purposes ~~among~~ between the accounts and among the subaccounts of the life insurance and annuity account ~~pursuant to~~ under 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. The amount of the class C assessment for long-term care insurance written by the impaired or insolvent insurer must be allocated according to a methodology included in the Plan of Operation and approved by the Commissioner. The methodology must provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to be allocated to life and annuity member insurers.

(3) Class C 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 3 most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to such premiums received in this State for such calendar years by all assessed member insurers.

(d) The Association may abate or defer, in whole or ~~in~~ part, the assessment of the 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~~ If an assessment against a member insurer is abated or deferred in whole or ~~in~~ part, the amount by which such 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~~ under this section. Once the conditions which 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)a. Subject to ~~the provisions of~~ paragraph (e)(1)b. of this section, 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 1 calendar year exceed 2% 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 3 calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

b. If 2 or more assessments are authorized in 1 calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in paragraph (e)(1)a. of this section shall be equal and limited to the higher of the 3-year average annual premiums for the applicable subaccount or account as calculated ~~pursuant to~~ under this section.

c. If the maximum assessment, together with the other assets of the Association in an account, does not provide in 1 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 chapter.

(2) The Board may provide in the plan of operation a method of allocating funds among claims, whether relating to 1 or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If the maximum assessment for any subaccount of the life and annuity account in any 1 year does not provide an amount sufficient to carry out the responsibilities of the Association, then ~~pursuant to~~ under paragraph (c)(3) of this section, the Board shall assess all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in paragraph (e)(1) of this section.

(f) The Board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of 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~~ 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~~ insurance, managed care organization, or health maintenance organization business 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 member insurer paying a class C 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 given equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member 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.

(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.~~ insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the Association.

Section 6. Amend § 4411, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4411. Duties and powers of Commissioner.

In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The Commissioner shall:

a. Upon request of the Board of Directors, provide the Association with a statement of the premiums in the appropriate states for each member insurer;

b. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this chapter; and

c. In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Commissioner shall be appointed conservator.

(2) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact ~~insurance~~ business in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. ~~As an alternative~~ Alternatively, the Commissioner may levy a forfeiture of any insurer which fails to pay an assessment when due. Such forfeiture shall not exceed 5% of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(3) A final action of the Board of Directors or the Association may be appealed to the Commissioner by a member insurer if the appeal is taken within 60 days of its receipt of notice of the final action being appealed. A final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this State that apply to the actions or orders of the Commissioner.

(4) The liquidator, ~~rehabilitator~~ rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

Section 7. Amend § 4412, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4412. Detection and prevention of insolvencies.

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

(1) It shall be the duty of the Commissioner:

a.1. To notify the commissioners of all the other ~~states, territories of the United States and the District of Columbia when he or she~~ states when the Commissioner takes any of the following actions against a member insurer:

1. A. Revocation of license;

2. B. Suspension of license;

3. C. Makes any formal order that such ~~company~~ member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its ~~business~~ business, or increase capital, ~~surplus~~ surplus, or any other account for the security of ~~policyholders~~ policyholders, policy owners, contract owners, certificate holders, or creditors.

2. ~~Such notice shall~~ Notice under paragraph (1)a.1. of this section must be mailed to all commissioners within 30 days following the action taken or the date on which such action occurs;

b. To report to the Board of Directors when ~~he or she~~ the Commissioner has taken any of the actions set forth in paragraph ~~(1)a.~~ (1)a.1. of this section or has received a report from any other commissioner indicating that

any such action has been taken in another state. Such report to the Board of Directors shall contain all significant details of the action taken or the report received from another commissioner;

c. To report to the Board of Directors when ~~he or she~~ the Commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that such company may be an impaired or insolvent insurer; and

d. To furnish to the Board of Directors the NAIC Early Warning Tests developed by the National Association of Insurance Commissioners, and the Board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein shall be kept confidential by the Board of Directors until such time as made public by the Commissioner or other lawful authority.

(2) The Commissioner may seek the advice and recommendations of the Board of Directors concerning any matter affecting ~~his or her~~ the Commissioner's duties and responsibilities regarding the financial condition of member ~~companies~~ insurers and ~~companies~~ insurers, managed care organizations, or health maintenance organizations seeking admission to transact ~~insurance~~ business in this State.

(3) The Board of Directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, ~~rehabilitation~~ rehabilitation, or conservation of any member insurer or germane to the solvency of any ~~company~~ insurer, managed care organization, or health maintenance organization seeking to do ~~an insurance~~ business in this State. Such reports and recommendations shall not be considered public documents.

(4) 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.

(5) 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 member insurer. Within 30 days of the receipt of such request, the Commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the Commissioner designates. The cost of such examination shall be paid by the Association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the Board of Directors ~~prior to~~ before its release to the public, but this shall not preclude the Commissioner from complying with paragraph (1) 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 ~~prior to~~ before the release of the examination report to the public.

(6) The Board of Directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of member insurer insolvencies.

(7) The Board of Directors shall, at the conclusion of any member insurer insolvency in which the Association was obligated to pay covered claims, prepare a report to the Commissioner containing such information as it may have in its possession bearing on the history and causes of such 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 for insolvency of a particular member insurer, and may adopt by reference any report prepared by such other associations.

Section 8. Amend § 4413, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4413. Credits for assessments paid.

(a) A member insurer may offset against its premium tax liability to this State an assessment described in § 4409(h) of this title to the extent of 20 percent of the amount of such assessment for each of the 5 calendar years following the year in which such assessment was paid. ~~In the event~~ If a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(b) Any sums acquired by refund, ~~pursuant to~~ under § 4409(f) of this title, from the Association which have theretofore been written off by contributing insurers and offset against ~~(premium, franchise or income)~~ premium, franchise, or income taxes as provided in subsection (a) ~~above,~~ of this section and are not then needed for purposes of this chapter, shall be paid by the Association to the Commissioner and deposited by the Commissioner with the State Treasurer for credit to the General Fund of this State.

Section 9. Amend § 4414, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4414. Liability for unpaid assessments; Association records; Association as creditor; liquidation proceeding.

(c) For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee ~~pursuant to~~ under § 4408(k) of this title. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered ~~policies,~~ policies or contracts, as used in this subsection, is that proportion of the assets which the reserves that should have been established

for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in subsection (c) of this section and consistent with § 5911 of this title, the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within 120 days of a final determination of insolvency of ~~an~~ a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

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

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the Association for funds expended in carrying out its powers and duties under § 4408 of this title with respect to such member insurer have been fully recovered by the Association.

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

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

(3) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions that person received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared shall be liable up to the amount of distributions that

person would have received if they had been paid immediately. If 2 persons are liable with respect to the same distributions, they shall be jointly and severally liable.

Section 10. Amend § 4419, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4419. Advertising.

No person, including ~~an~~ a member insurer, agent or affiliate of ~~an~~ a member insurer shall make, publish, disseminate, ~~circulate~~ circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, ~~circulated~~ circulated, or placed before the public, in any newspaper, ~~magazine~~ magazine, or other publication, or in the form of a notice, circular, pamphlet, ~~letter~~ letter, or poster, or over any radio station or television station, or in any other way, any advertisement, ~~announcement~~ announcement, or statement which uses the existence of the Insurance Guaranty Association of this State for the purpose of sales, ~~solicitation~~ solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter. Provided, however, that this section shall not apply to the Delaware Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit ~~insurance.~~ insurance or coverage by a managed care organization or health maintenance organization.

Section 11. Amend § 4419, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 6411. Relationship to other laws.

(a) Managed care organizations shall be subject to this chapter and to the following chapters of this title, as amended from time to time, to the extent applicable and not in conflict with the express provisions of this chapter. For purposes of the following chapters only, a managed care organization shall be treated as a health insurer, and its coverages shall be deemed to be "medical and hospital expense-incurred insurance policies" for purposes of Chapter 25 of this title:

(20) Chapter 44 of this title (Delaware Life and Health Insurance Guaranty Association).

SYNOPSIS

This Act updates the Delaware Life and Health Insurance Guaranty Association Act (Delaware Act) to conform Delaware law to revisions made to the National Association of Insurance Commissioners' (NAIC) Life and Health Insurance Guaranty Association Model Act (Model Act).

The Model Act provides a framework for protecting policy or contract owners, insureds, beneficiaries, annuitants, payees, and assignees against losses due to the insolvency or impairment of an insurer.

This Act revises the methodology for assessments relating to long-term care insurance written by an impaired or insolvent insurer and includes managed care organizations and health maintenance organizations within the scope of the Delaware Act to more fairly distribute the cost of long-term care insurance insolvencies among insurers writing life, health, annuity, managed care organization, and health maintenance organization products and to ensure sufficient assessment capacity for all insolvencies.

Finally, this Act makes technical corrections to conform existing law to the standards of the Delaware Legislative Drafting Manual.

Author: Senator Paradee