SPONSOR: Rep. Stone & Sen. Cook

HOUSE OF REPRESENTATIVES

141st GENERAL ASSEMBLY

HOUSE BILL NO. 477

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

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

Section 1. Amend Title 18 Delaware Code Chapter 44, §4403, by striking §4403 in its entirety and substituting in lieu thereof:

"§4403. Coverage and Limitations.

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

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

(2) to persons who are owners of or certificate holders 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 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 was not licensed in the state at the time specified in the state's guaranty association law.

(3) For unallocated annuity contracts specified in Subsection (b); 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. Persons who are the 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

b. 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); 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:

a. Is a resident, regardless of where the contract owner resides, or

b. Is not a resident, but only under both of the following conditions;

1.

(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

2. 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:

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 (3) of this subsection, if any coverage is provided by the association of another state to the person.

(6) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a non-resident. 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, 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) for direct, non-group life, health or annuity policies or contracts and supplemental 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, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(2) This chapter shall not provide coverage for the following:

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

b. any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

c. any 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;

1. averaged over the period of four 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 percentage points from Moody's Corporate Bond Yield Average averaged for that same four year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

2. 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 percentage points from Moody's Corporate Bond Yield Average as most recently available;

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 or other person under any of the following:

1. a Multiple Employer Welfare Arrangement as defined in 29 U. S. C. §1144;

2. a minimum premium group insurance plan;

3. a stop-loss group insurance plan; or

4. an administrative services only contract;

e. any portion of a policy or contract to the extent that it provides:

1. dividends or experience rating credits;

2. voting rights; or

3. payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of such policy or contract;

f. any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

g. any 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;

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

i. a portion of a policy or contract to the extent that the assessments required by Section 4409 of this Title with respect to the policy or contract are preempted by federal or state law;

j. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;

2. Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

3. Misrepresentations of or regarding policy benefits;

4. Extra-contractual claims or;

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

k. 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.

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 Section 4003(b)(2)a, 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 Section 2704(e) of this Title.

(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 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:

a. $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;

b. In health insurance benefits:

1. $100,000 for coverages not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance including any net cash surrender and net cash withdrawal values;

2. $300,000 for disability insurance. For purposes of this section "disability insurance" shall mean the type of policy which pays a monthly or weekly amount if you are disabled and cannot work.

3. $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 co-insurer pays the remainder; or

c. $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) with respect to each individual participating in a governmental retirement benefit plan established under §§401, 403(b) or 457 of the U. S. Internal Revenue Code covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased, $100,000 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), $100,000 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 one life under paragraphs (2)(A), (2)(B) and (2)(C) of this subsection except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance under paragraph (2)(A)b. of this subsection, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual, or (ii) with respect to one owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than $1,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(E) With respect to either (i) one contract owner provided coverage under Subsection (a)(3)b. of this section; or (ii) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in paragraph (2)(B) of this subsection, $1,000,000 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts 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 $1,000,000 in benefits with respect to all these unallocated contracts.

(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.

(d) In performing its obligations to provide coverage under Section 4408 of this chapter, the Association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured 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 2. Amend Title 18 Delaware Code Chapter 44, Section 4405 by striking section 4405 in its entirety and substituting in lieu thereof:

"Section 4405. Definitions

As used in this Chapter:

(a) "Account" means either of the two accounts created under Section 4406.

(b) "Association" means the Delaware Life and Health Insurance Guaranty Association created under Section 4406.

(c) "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.

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

(e) "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.

(f) "Commissioner" means the Commissioner of Insurance of this state.

(g) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 4403.

(h) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 4403.

(i) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs.

(j) "Impaired insurer" means a member insurer which, after the effective date of this Chapter, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

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

(l) "Member insurer" means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 4403, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

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

(2) A health maintenance organization;

(3) A fraternal benefit society;

(4) A mandatory state pooling plan;

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

(6) An insurance exchange;

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

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

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

(n) "Owner" of a policy or contract and "policy 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 insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(o) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(p) "Plan sponsor" means:

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

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

(3) In a 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.

(q) "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 Section 4403(b) except that assessable premium shall not be reduced on account of Sections 4403(b)(2)(C) relating to interest limitations and 4403(c)(2) relating to limitations with respect to one individual, one participant and one contract owner. "Premiums" shall not include:

(1) 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 Section 401, 403(b) or 457 of the United States Internal Revenue Code, or

(2) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy 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 $1,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(r)

(1) "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 similar governing person or persons) of the entity conducts the majority of its meeting;

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.

(2) The principal place of business of a plan sponsor of a benefit plan described in Subsection p(3) 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.

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

(t) "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. 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 insurer that issued the policies or contracts.

(u) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

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

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

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

Section 3. Amend Title 18 Delaware Code Chapter 44, §4406, subsection (a)(1) by striking subsection (a)(1) in its entirety and substituting in lieu thereof:

"(a)

(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 Section 401, 403(b) or 457 of the United States Internal Revenue Code, 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 Section 401, 403(b) or 457 of the United States Internal Revenue Code."

Section 4. Amend Title 18 Delaware Code Chapter 44, §4408, by striking §4408 in its entirety and substituting in lieu thereof:

"§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 or reinsure, or cause to be guaranteed, assumed, 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 (1) and assure payment of the contractual obligations of the impaired insurer pending action under Paragraph (1).

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

(1)

a.

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

(ii) 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, 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:

(i) With respect to group polices and contracts, not later than the earlier of the next renewal date under those 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 and contracts;

(ii) With respect to non-group polices, 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 or contracts;

b. Make diligent efforts to provide all known insureds or annuitants (for non-group policies and contracts), or group policy owners with respect to group policies and contracts, thirty (30) days notice of the termination (pursuant to Subparagraph (a) of this paragraph) of the benefits provided;

c. With respect to non-group life and health insurance policies and annuities covered by the Association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of Subparagraph (d), if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class:

d.

(i) In providing the substitute coverage required under Subparagraph (c), the Association may offer either to reissue the terminated coverage or to issue an alternative policy.

(ii) 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.

(iii) The Association may reinsure any alternative or reissued policy;

e.

(i) 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 of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates 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 was last underwritten.

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

f. If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner and the receivership court;

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

h. When proceeding under this Subsection b(2) 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 Section 4403(b)(2)c.

(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 or coverage under this Chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this 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, and 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 the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this sate.

(f) In carrying out its duties under Subsection b, the Association may:

(1) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a 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 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 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 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 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 owners claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the Association and retained pursuant to this subsection. Any amount so paid to the Association less the amount retained by it shall be treated as a distribution of estate assets pursuant to §5911 of this title, or similar provision of the state of domicile of the impaired or insolvent insurer.

(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 insurer.

(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 an 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, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court 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 coverages. The Association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this 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 (1) and (2) above, 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 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 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 Section 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 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 of this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies (or portion thereof) covered by the Association.

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

(1) Enter into such 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 Section 4409 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 such persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this Chapter;

(5) Take such legal action as 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 or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform its obligations under this Chapter;

(7) Organize itself as a corporation or in other legal form permitted by the laws of the 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) 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) At any time within one year after the date on which the Association becomes responsible for the obligations of a member insurer (the coverage date), the Association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to contracts covered (in whole or in part) by the Association, under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the Association. However, the Association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator or liquidator and to the affected reinsurers. If the Association makes an election, Subparagraphs (a) through (d) below shall apply with respect to the agreements selected by the Association:

a. The Association shall be responsible for all unpaid premiums due under the agreements (for periods both before and after the coverage date), and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered (in whole or in part) by the Association. The Association may charge contracts covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association;

b. The Association shall be entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the Association (in whole or in part), provided that, upon receipt of any such amounts, the Association shall be obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of:

   (i) The amount received by the Association, over

   (ii) The benefits paid by the Association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event;

c. Within thirty (30) days following the Association's election, the Association and each indemnity reinsurer shall calculate the net balance due to or from the Association under each reinsurance agreement as of the date of the Association's election, giving full credit to all items paid by either the member insurer (or its receiver, rehabilitator or liquidator) or the indemnity reinsurer during the period between the coverage date and the date of the Association's election. Either the Association or indemnity reinsurer shall pay the net balance due the other within five (5) days of the completion of the aforementioned calculation. If the receiver, rehabilitator or liquidator has received any amounts due the Association pursuant to Subparagraph (b), the receiver, rehabilitator or liquidator shall remit the same to the Association as promptly as practicable.

d. If the Association, within sixty (60) days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the Association (in whole or in part), the reinsurer shall not be entitled to terminate the reinsurance agreements insofar as the agreements relate to contracts covered by the Association (in whole or in part) other than for a subsequent premium default by the Association and shall not be entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the Association.

(2) In the event the Association transfers its obligations to another insurer, and if the Association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the Association under paragraph (1) effective as of the date agreed upon by the Association and the other insurer and regardless of whether the Association has made the election referred to above in Paragraph (1) provided that:

a. The indemnity reinsurance agreements shall automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

b. The obligations described in the proviso to Paragraph (1)(b) of this subsection shall no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer; and

c. This paragraph (2) shall not apply if the Association has previously expressly determined in writing that it will not exercise the election referred to in Paragraph (1);

(3) The provisions of this subsection shall supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator or rehabilitator of the insolvent member insurer. The receiver, rehabilitator or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date (subject to applicable setoff provisions); and

(4) Except as otherwise expressly provided above, nothing herein shall alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. Nothing herein shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. Nothing herein shall give a

policyowner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

(o) The Board of Directors of the Association shall have discretion and may 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 the Chapter shall be in New Castle 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.

(r) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under Subsections (a) or (b), 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:

(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 for 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 materials terms."

Section 5. Amend Title 18 Delaware Code Chapter 44, §4409, by striking §4409 in its entirety and substituting in lieu thereof:

"§4409. 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 members insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at 10% per annum on and after the due date.

(b) There shall be three classes of assessment as follows:

(1) Class A assessments, shall be authorized and called for the purpose of meeting administrative 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 annually to provide for the oversight activity of the Commissioner, thereby minimizing the need to make Class C assessments.

(3) Class C assessments shall be authorized and called to the extent necessary to carry out the duties of the Association under this title with regards to an impaired or insolvent member 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 C assessments. The total of all non pro rata assessments shall not exceed $150 per member insurer in any one calendar year. The amount of Class C assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) The amount of a Class B assessment shall be determined by the Commissioner who shall so notify the Association not later than July 31 of the calendar year in which the assessment is to be made. A Class B assessment may be made on a non-pro rata basis, but the amount shall not exceed one tenth of one percent of the members premium written during the calendar year preceding the assessment. The amount assessed in conjunction with Class C assessments shall not result in members being assessed more than 2% of the premiums written in the applicable year. The proceeds of this assessment shall be paid by the Association into the Commissioner’s Regulatory Revolving Fund.

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

(4) 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 determination 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 180 days after the assessment is authorized.

(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 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 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 Subparagraph (b) 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 one calendar year exceed two percent (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 three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

b. 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 (a) of this paragraph shall be equal and limited to the higher of the three-

year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

c. If the maximum assessment, together with the other assets of the Association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this 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 any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to 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) above.

(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 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 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 protests 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 6. Amend Title 18 Delaware Code Chapter 44, §4411(3), by striking §4411(3) in its entirety and substituting in lieu thereof:

"§4411(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 sixty (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."

Section 7. Amend Title 18 Delaware Code Chapter 44, §4414, by striking §4414 in its entirety and substituting in lieu thereof:

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

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

(b) Records shall be kept of all meetings of the Board of Directors to discuss the activities of the Association in carrying out its powers and duties under §4408 of this title. The records of the Association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under §4415 of this title.

(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 §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, as used in this subsection, is that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) 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 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 the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders and 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 of the continuing or successor insurer.

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

(f)

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

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

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If 2 persons are liable with respect to the same distributions, they shall be jointly and severally liable.

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

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

Ssynopsis

Section 1

This section deletes existing Section 4403 and replaces it with a new section 4403. Coverage and Limitations. Which is based on section 3 of the National Association of Insurance Commissioners Life and Health Insurance Guaranty Association Model Act. Among the major changes are the following:

1. There is a change that clarifies the circumstance under which a guaranty association will cover non-resident policyholders. The change makes clear that non-resident coverage is available only if coverage from the resident state is unavailable due to the insolvent insurer not being licensed in that state at the relevant time.
2. The amendment incorporates language that would change the situs of trust owned unallocated annuity contracts from the state of the contract owner to the state of the plan sponsor. This change will minimize concentration of coverage liabilities in the state of residence of trustee owners that are particularly active in the plan trust area. This change will also inhibit plan sponsors from forum shopping for guaranty association coverage by using a trustee owner to establish residency in a state with more favorable coverage.
3. Coverage for structured settlement annuities is switched from the state of residence of the contract holder to the state of residence of the payee. The way these annuities are written, the current law results in concentrating the situs in an artificially small number of states where the contract holders reside, in turn distorting assessment patterns and risking strain on capacity.
4. There is a change to clarify that the interest rate adjustment provision applies to equity indexed products.
5. There is a revision to clarify that the exclusion from coverage under the guaranty association act of any unallocated annuity contract issued to either an employee, an employer, a trust or otherwise in connection with the benefit plan protected under the federal Pension Benefit Guaranty Corp, applies regardless of whether the PBGC is currently liable to make any payments.
6. There is an amendment to clarify that guaranty association coverage should be made available only for express contractual obligations and that the resources of the guaranty association should not be expended on claims which fall outside the terms of a policy contract.
7. There is an amendment that provides that “synthetic” GIC’s are excluded from the guaranty association system. These products did not exist at the time the prior law was enacted.
8. There is an amendment that clarifies that coverage is provided for equity indexed products.
9. The amendment increases the coverage limits for certain health insurance benefits. Prior law provided $100,000 of coverage for all health insurance coverages. The amendment would increase the limit to $500,000 for hospital, medical, surgical and major medical insurance and to $300,000 for disability insurance. Other health insurance benefits would continue at $100,000.
10. There is a provision to clarify that the guaranty association is responsible only for the shortfall in estate assets within covered limits and that therefore estate assets attributable to covered policies may reduce the amounts for which the association is responsible. This amendment reflects the long standing practices of the Guaranty Association and Receivers.

Section 2

Amends the Act by deleting the existing Section 4405 and replacing it in its entirety with a new Section 4405. Definitions.

This section incorporates new and revised definitions into the Act consistent with the changes being made elsewhere in the bill. Among the changes are:

1. The addition of a definition of “principal place of business”. This was done to assist in achieving consistent determinations of the state of residence of a person other than a natural person, which is their principal place of business. This definition appears at Section 4405 (r).
2. A definition of “structured settlement annuity” has been added. This is not previously defined in the Act.
3. Such other terms such as “authorized assessment”, “benefit plan”, “called assessment”, “extra contractual claims”, “owner”, “plan sponsor”, and “receivership” have all been added to the Act. None of these terms have been previously defined.

Section 3

This section of the bill amends Section 4406 (a) (1) of the Act. This change makes clarifications in the annuity and unallocated annuity sub accounts of the life and annuity assessment accounts, specifically with respect to governmental retirement plans. This is simply a technical correction to make the Delaware Act consistent with the

NAIC Model.

Section 4

This section deletes existing Section 4408 and replaces it with a new Section 4408. Powers and Duties of the Association. The revision to this section is based on Section 8 of the National Association of the National Association of Insurance Commissioners Life and Health Insurance Guaranty Association Model Act. Among the major changes are the following:

1. The guaranty association's authority to provide substitute coverage was expanded to include annuities. A related change was to authorize the domiciliary insurance commissioner and the receivership court to approve alternative policies used by guaranty associations in providing substitute coverage. The result of these changes is to facilitate the use of substitute coverage in connection with national plans for covering policyholders. The use of substitute coverage can be beneficial in cases where the insolvent insurer has a multitude of unusual policy forms.
2. The guaranty association would be granted express assignment rights with respect to the insolvent insurer's ceded indemnity reinsurance. Those rights can be of significant benefit to the guaranty association in transferring covered obligations to a healthy insurer because in certain cases assuming carriers will insist that the reinsurance be transferred as well.
3. The guaranty association's authority to act in cases of impaired insurers was expanded to include foreign as well as domestic insurers.
4. A clarification is made that policyholders that opt out of the guaranty association plan for fulfilling coverage obligations are not entitled to alternative benefits from the guaranty association. This provision will facilitate and protect the use of cost effective national plans for fulfilling guaranty association coverage obligations and is consistent with long standing guaranty association practice.
5. The existing provision allowing the guaranty association to impose temporary policy moratoria and liens was expanded to clarify that the guaranty association could also rely on temporary moratoria issued by the receivership court. This provision will allow guaranty associations and receivers to develop national plans that best utilize the resources of the estate and the guaranty association for the benefit of policyholders generally.
6. A provision was added clarifying that the guaranty associations' automatic assignment rights with respect to covering policyholder obligations extends to causes of action that covered policyholders may have against third parties.

Section 5

This section deletes existing Section 4409 and replaces it with a new Section 4409. Assessments. The new Section 4409 is based on Section 9 of the National Association of Insurance Commissioners Life and Health Insurance Guaranty Association Model Act. Among the major changes are the following:

1. The procedures for handling member insurer protests of guaranty association assessments is simplified and organized to facilitate the resolution of such disputes.
2. There is a change that allows the Association flexibility to authorize and call assessments in different years. This codifies existing practices of the guaranty association.
3. Another change eliminates the 1% rollover requirement between life and annuity assessment sub accounts. This requirement was difficult to administer and used capacity in a non-affected line of business before the affected line had utilized its full capacity.
4. Changes were made which clarify how the Association should calculate its annual assessment capacity when it makes assessments in the same calendar year for insolvencies occurring in different calendar years.

Section 6

This section of the bill amends Section 4411(3) of the Act. This change provides that any final action taken by the Board may be appealed by a member insurer to the Commissioner within sixty (60) days after receipt of notice of the final decision by the member insurer. The time period is intended to be consistent with Section 4409(i)(3).

Section 7

Amends the Act by deleting the existing §4414 and replacing it in its entirety with a new Section 4414. The new Section 4414 is based on Section 14 of the NAIC Life & Health Insurance Guaranty Association Model Act. Among the major changes are the following:

1. There is a change which limits application of the record keeping requirements of the guaranty association to meetings of its Board of Directors. It recognizes that it is highly impractical to expect that an association will keep

records of all interchanges which might qualify as negotiations and meetings.

2. Another change to this section is intended to strengthen the association's ability to maintain the confidentiality of its records during the pendency of a liquidation, rehabilitation or conservation proceeding.
3. There is a modification that is consistent with Section 38 of the Rehabilitation and Liquidation Model Act. It confirms the guaranty association's entitlement to the receipt of assets out of the marshaled assets of the estate as credits against contractual obligations that the association has paid. This modification is intended to assure availability of estate assets to the guaranty association so that they would not be required to fund obligations of policyholders and claimants without the benefit of early access distributions.