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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1195 Session of 2020

INTRODUCED BY SCAVELLO AND STREET, JUNE 9, 2020

SENATOR BROWNE, APPROPRIATIONS, RE-REPORTED AS AMENDED, JUNE 29, 2020

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An
2 act relating to insurance; amending, revising, and
3 consolidating the law providing for the incorporation of
4 insurance companies, and the regulation, supervision, and
5 protection of home and foreign insurance companies, Lloyds
6 associations, reciprocal and inter-insurance exchanges, and
7 fire insurance rating bureaus, and the regulation and
8 supervision of insurance carried by such companies,
9 associations, and exchanges, including insurance carried by
10 the State Workmen's Insurance Fund; providing penalties; and
11 repealing existing laws," in general provisions relating to
12 insurance companies, associations and exchanges, further
13 providing for Reinsurance Credits and providing for credit
14 for reinsurance and reciprocal jurisdictions; in Life and
15 Health Insurance Guaranty Association, further providing for
16 purpose, for definitions, for coverage and limitations, for
17 creation of association, for board of directors, for powers
18 and duties of association, for assessments, for plan of
19 operation, for powers and duties of the commissioner, for
20 prevention of insolvencies, for credits for assessments paid,
21 for miscellaneous provisions, for examination of the
22 association and annual report, for immunity, for stay of
23 proceedings and reopening default judgments, for prohibited
24 advertisement or Insurance Guaranty Association Act in
25 insurance sales and for prospective application.

26 The General Assembly of the Commonwealth of Pennsylvania
27 hereby enacts as follows:

28 Section 1. Section 319.1(a), (b) and (f) of the act of May
29 17, 1921 (P.L.682, No.284), known as The Insurance Company Law

of 1921, are amended and the section is amended by adding subsections to read:

Section 319.1. Reinsurance Credits.--[(a) Unless an unlicensed reinsurer is qualified or certified to accept reinsurance from insurers licensed in this Commonwealth, no credit shall be allowed as an admitted asset or as a reduction of liability relative to risks ceded by such licensed insurers. Qualified or certified reinsurers are those meeting the conditions for reinsurers specified by the commissioner, in his discretion, and included on a list of qualified or certified reinsurers published and periodically reviewed by said commissioner.]

(a.1) A domestic ceding insurer may take a credit for reinsurance as either an asset or reduction from liability on account of the reinsurance ceded if it meets the requirements specified in this section.

(a.2) The following types of reinsurance arrangements are permissible:

(1) Reinsurance ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this Commonwealth in accordance with section 319(b).

(2) Reinsurance ceded to an insurer meeting the conditions specified by the commissioner, in the commissioner's discretion, and included on a list of qualified or certified reinsurers published and periodically reviewed by the commissioner including when the reinsurance is ceded to the following:

(i) An assuming foreign or alien insurer or group of incorporated alien insurers under common administration that has BEEN deemed to be a qualified reinsurer by the commissioner in accordance with the requirements of 31 Pa. Code Ch. 161

1 (relating to requirements for qualified and certified
2 reinsurers).
3 (ii) An assuming insurer that has been certified by the
4 commissioner as a reinsurer in this Commonwealth in accordance
5 with the requirements of 31 Pa. Code Ch. 161, except that as of
6 the effective date of this subsection, the following shall
7 apply:
8 (A) Certified reinsurers not domiciled in the United States
9 must submit the most recent audited financial statements,
10 regulatory filings and actuarial opinions, as filed with the
11 certified reinsurer's supervisor, with a translation into
12 English, but shall not need to submit audited financial
13 statements on a United States generally accepted accounting
14 principles or international financial reporting standards
15 basis.
16 (B) Upon the initial application for certification pursuant
17 to 31 Pa. Code~~.~~ Ch. 161, the commissioner shall consider audited <--
18 financial statements for the last two years filed with the
19 certified reinsurer's supervisor.
20 (3) Reinsurance ceded to an assuming insurer meeting the
21 requirements of section 319.3.
22 (4) Reinsurance ceded to an assuming insurer that is
23 domiciled in, or for a United States branch of an alien assuming
24 insurer~~,~~ is entered through, a state that employs standards <--
25 regarding credit for reinsurance substantially similar to those
26 applicable under the law of this Commonwealth and the assuming
27 insurer or United States branch of an alien assuming insurer
28 meets both of the following:
29 (i) Maintains a surplus as regards policyholders in an
30 amount not less than $20,000,000, except with regard to

reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(ii) Submits to the authority of the commissioner to examine its books and records.

(b) A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer [which is not a qualified or certified reinsurer in accordance with this section] not falling within one of the categories specified under subsection (a.2) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer and such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held in a qualified United States financial institution, as defined in subsection (g)(2). This security may be in the form of:

(1) Cash.

(2) Securities listed by a securities valuation office of a national association of insurance commissioners or any successor thereto, including those exempted from filing under the Purposes and Procedures Manual of the Securities Valuation Office of the National Association of Insurance Commissioners, and qualifying as admitted assets.

(3) (i) Clean, irrevocable, unconditional and evergreen letters of credit issued or confirmed by a qualified United States financial institution, as defined in subsection (g)(1), effective no later than the thirty-first day of December in

respect of the year for which filing is being made and in the possession of the ceding insurer on or before the filing date of its annual statement.

(ii) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

(4) Funds or letters of credit provided by a noninsurer parent corporation of the ceding insurer, in lieu of the funds to be withheld by the ceding insurer under a reinsurance contract with such assuming insurer as security for payment of obligations thereunder, if the following requirements are met:

(i) The funds or letters of credit are held subject to withdrawal by and under the control of the ceding insurer.

(ii) The type, amount and form of the funds or letters of credit receive the prior approval of the Insurance Commissioner.

(5) Any other form of security acceptable to the Insurance Commissioner.

* * *

(f) The following shall apply:

(1) Notwithstanding the provisions of this section, the Insurance Department may promulgate one or more regulations to limit, prohibit or authorize the credit which a domestic insurer may take as an admitted asset or as a reduction in liability with respect to reinsurance ceded on any financial statements filed with the Insurance Department.

(2) In addition to and notwithstanding the commissioner's

1 regulatory authority under paragraph (1), the commissioner may
2 promulgate regulations as provided under this paragraph.
3 (i) A regulation promulgated under this paragraph shall
4 only apply to reinsurance relating to the following:
5 (A) Life insurance policies with guaranteed nonlevel gross
6 premiums or guaranteed nonlevel benefits.
7 (B) Universal life insurance policies with provisions
8 resulting in the ability of a policyholder to keep a policy in
9 force over a secondary guarantee period.
10 (C) Variable annuities with guaranteed death or living
11 benefits.
12 (D) Long-term care insurance policies.
13 (E) Other life and health insurance and annuity products
14 related to credit for reinsurance.
15 (ii) A regulation promulgated under this paragraph may apply
16 to treaties entered into after the effective date of this
17 paragraph containing:
18 (A) policies issued after December 31, 2014;
19 (B) policies issued prior to January 1, 2015, if risk
20 pertaining to the policies is ceded in connection with the
21 treaty, in whole or in part, after December 31, 2014 ; or
22 (C) policies that meet the requirements of both clauses (A)
23 and (B).
24 (iii) A regulation promulgated under this paragraph may not
25 apply to cessions to an assuming insurer if the assuming insurer
26 meets one of the following:
27 (A) Meets the requirements under section 319.3.
28 (B) Is certified in this Commonwealth.
29 (C) The commissioner has determined that the assuming
30 insurer maintains at least $250,000,000 (two hundred and fifty

1 million dollars) in capital and surplus and is either of the
2 following:
3 (I) licensed in at least 26 states; or
4 (II) licensed in at least ten states and licensed or
5 accredited in a total of at least 35 states.
6 * * *
7 Section 1.1. The act is amended by adding a section to read:
8 Section 319.3. Credit For Reinsurance And Reciprocal
9 Jurisdictions.--(a) The commissioner shall allow credit for
10 reinsurance ceded by a domestic insurer to an assuming insurer
11 that is licensed to write reinsurance by, and has its head
12 office or is domiciled in, a reciprocal jurisdiction that meets
13 the requirements of this section.
14 (b) (Reserved).
15 (c) Credit shall be allowed if reinsurance is ceded from an
16 insurer domiciled in this Commonwealth to an assuming insurer
17 meeting each of the following conditions:
18 (1) The assuming insurer must be licensed to transact
19 reinsurance by and have its head office or be domiciled in a
20 reciprocal jurisdiction.
21 (2) The assuming insurer must have and maintain on an
22 ongoing basis minimum capital and surplus, or its equivalent,
23 calculated on at least an annual basis as of the preceding
24 December 31 or at the annual date otherwise statutorily reported
25 to the reciprocal jurisdiction, and confirmed as provided under
26 paragraph (7) according to the methodology of its domiciliary
27 jurisdiction in the following amounts, which may be modified by
28 the commissioner by regulation:
29 (i) at least $250,000,000; or
30 (ii) if the assuming insurer is an association, including

incorporated and individual unincorporated underwriters:

(A) minimum capital and surplus equivalents, net of liabilities, or own funds of the equivalent of at least $250,000,000; and

(B) a central fund containing a balance of the equivalent of at least $250,000,000.

(3) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as follows:

(i) if the assuming insurer has its head office or is domiciled in a reciprocal jurisdiction as provided under paragraph (1) of the definition of "reciprocal jurisdiction," the ratio specified in the applicable covered agreement;

(ii) if the assuming insurer is domiciled in a reciprocal jurisdiction under paragraph (2) of the definition of "reciprocal jurisdiction", a risk-based capital ratio of 300% of the authorized control level calculated in accordance with the formula developed by the National Association of Insurance Commissioners; or

(iii) if the assuming insurer is domiciled in a reciprocal jurisdiction under paragraph (3) of the definition of "reciprocal jurisdiction", after consultation with the reciprocal jurisdiction and considering any recommendations published through the National Association of Insurance Commissioners committee process, the solvency or capital ratio as the commissioner determines to be an effective measure of solvency.

(4) The assuming insurer must agree to and provide adequate assurance, by executing a form as prescribed by the commissioner, of its agreement to the following:

(i) The assuming insurer must agree to provide prompt

written notice and explanation to the commissioner if it falls below the minimum requirements under paragraphs (2) and (3) , or if any regulatory action is taken against it for serious noncompliance with law.

(ii) The assuming insurer must consent in writing to the jurisdiction of the courts of this Commonwealth and to the appointment of the commissioner as agent for service of process.

(A) The commissioner may require that the consent be provided and included in each reinsurance agreement under the commissioner's jurisdiction.

(B) Nothing under this paragraph shall limit or alter the capacity of a party to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent the agreements are unenforceable under applicable insolvency or delinquency laws.

(iii) The assuming insurer must consent in writing to pay each final judgment, wherever enforcement is sought, obtained by a ceding insurer, that have been declared unenforceable in the territory where the judgment was obtained.

(iv) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to the agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of this estate, if applicable.

(v) The assuming insurer must:

(A) Confirm that it is not presently participating in a

solvent scheme of arrangement, which involves this Commonwealth's ceding insurers.

(B) Agree to notify the ceding insurer and the commissioner if it enters into a solvent scheme of arrangement.

(C) Agree to provide security to the ceding insurer in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer if the assuming insurer enters into a solvent scheme of arrangement.

(D) Agree to provide security in a form consistent with all of the following:

(I) The provisions of section 319.1(a.2)(2) applicable to certified reinsurers.

(II) Section 319.1(b).

(III) 31 Pa.Code Ch. 163 (relating to requirements for funds held as security for the payment of obligations of unlicensed, unqualified reinsurers).

(E) For purposes of this subparagraph, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed class members or creditors of a solvent debtor on a final basis, and which may be subject to jurisdictional recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.

(vi) An assuming insurer shall agree in writing to meet the applicable information filing requirements of paragraph (5) of this subsection.

(5) An assuming insurer or its legal successor shall

provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the following documentation to the commissioner:

(i) for the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;

(ii) for the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;

(iii) prior to entry into the reinsurance agreement and not more often than semi-annually thereafter, an updated list of each disputed and overdue reinsurance claims outstanding for at least 90 days, regarding reinsurance assumed from ceding insurers domiciled in the United States; and

(iv) prior to entry into the reinsurance agreement and not more often than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria under paragraph (6).

(6) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment shall be evidenced by any of the following criteria:

(i) More than 15% of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the

commissioner.

(ii) More than 15% of the assuming insurer's reinsurance recoverables on paid losses are at least 90 days overdue, are not in dispute and exceed $100,000 for each ceding insurer or as otherwise specified in a covered agreement.

(iii) The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by at least 90 days, exceeds $50,000,000 or as otherwise specified in a covered agreement.

(7) The assuming insurer's supervisor shall confirm, in writing, to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction that the assuming insurer complies with the requirements under paragraphs (2) and (3).

(8) Nothing under this subsection shall preclude an assuming insurer from providing the commissioner with information on a voluntary basis.

(c.1) The department shall publish the prescribed form under subsection (c)(4) on the department's Internet website and shall submit the form to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(d) The commissioner shall timely create and publish a list of reciprocal jurisdictions on the department's Internet website and shall submit the list to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin. The following shall apply:

(1) A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners committee process. The commissioner shall include on the list any

reciprocal jurisdiction the meets the requirements of subsection (k)(1) and (2).

(2) The commissioner shall consider any other reciprocal jurisdiction that is included on the list of reciprocal jurisdictions published through the National Association of Insurance Commissioners committee process.

(3) The commissioner may approve a jurisdiction that does not meet the requirements of subsection (k)(1) or (2) as provided by law, regulation or in accordance with criteria published through the National Association of Insurance Commissioners committee process.

(4) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of this section or other law or regulation, or in accordance with a process published through the National Association of Insurance Commissioners committee process, except that the commissioner may not remove a reciprocal jurisdiction that meets the requirements of subsection (k)(1) or (2). Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in a jurisdiction shall be allowed only if allowed under section 319.1.

(e) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions under this section and to which cessions shall be granted credit. The following shall apply:

(1) The commissioner shall create the list in accordance with the following requirements:

(i) The commissioner may add an assuming insurer to the list

if an National Association of Insurance Commissioners-accredited jurisdiction has added the assuming insurer to a list of the assuming insurers.

(ii) The commissioner may add an assuming insurer to the list if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under subsection (c)(4) and complies with any additional requirements the commissioner may impose by regulation, except to the extent that the the additional requirements conflict with an applicable covered agreement.

(iii) If a National Association of Insurance Commissioners-accredited jurisdiction has determined that the conditions under subsection (c) have been met, the commissioner may defer to the jurisdiction's determination and add the assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The commissioner may accept financial documentation filed with another National Association of Insurance Commissioners-accredited jurisdiction or with the National Association of Insurance Commissioners in satisfaction of the requirements of subsection (c).

(iv) If requesting that the commissioner defer to another National Association of Insurance Commissioners-accredited jurisdiction's determination, the assuming insurer shall execute the form under subsection (c)(4) and provide additional information required by the commissioner. A state that has received such a request must notify other state insurance regulators through the National Association of Insurance Commissioners committee process and provide the relevant information with respect to the determination of eligibility.

(2) If the commissioner determines that an assuming insurer

no longer meets one or more of the requirements under this section, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this section.

(i) While an assuming insurer's eligibility is suspended, a reinsurance agreement issued, amended or renewed after the effective date of the suspension may not qualify for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with section 319.1(b).

(ii) If an assuming insurer's eligibility is revoked, a credit for reinsurance may not be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner in accordance with section 319.1(b).

(f) Before denying statement credit or imposing a requirement to post security under section 319.1(b)(2) or adopting an similar requirement that will have substantially the same regulatory impact on security, the commissioner shall:

(1) Communicate with the ceding insurer, the assuming insurer and the assuming insurer's supervisor that the assuming insurer no longer satisfies one of the conditions listed in subsection (c).

(2) Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect and 90 days from the initial communication to remedy the defect except in exceptional circumstances in which a shorter period is necessary for policyholder and consumer protection.

(3) After the expiration of the period under paragraph (2), if the commissioner determines that no or insufficient action was taken by the assuming insurer, the commissioner may take any of the actions provided under this subsection.

(4) Provide a written explanation to the assuming insurer of any of the requirements under this subsection.

(g) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer or its representative may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(h) Nothing under this subsection shall limit or alter the capacity of a party to a reinsurance agreement to agree on requirements for security or other terms in the reinsurance agreement, except as expressly prohibited under section 319 or other law or regulation.

(i) Credit may be taken under this section only for reinsurance agreements entered into, amended or renewed on or after the effective date of this section and only with respect to losses incurred and reserves reported on or after the later of the date on which the assuming insurer has met all eligibility requirements under subsection (a), and the effective date of the new reinsurance agreement, amendment or renewal. The following shall apply:

(1) This subsection shall not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other provision of section 319.1.

(2) Nothing under this subsection shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(3) Nothing under this subsection shall limit or alter the capacity of a party to any reinsurance agreement to renegotiate the agreement.

(j) The commissioner may promulgate regulations to carry out the provisions of this section.

(k) For the purposes of this section, a "reciprocal jurisdiction" means a jurisdiction, as designated by the commissioner under subsection (d) that meets one of the following requirements:

(1) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority or, for a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this paragraph, a "covered agreement" is an agreement entered into under 31 U.S.C. §§ 313 (relating to Federal Insurance Office) and 314 (relating to covered agreements) that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this Commonwealth or for allowing the ceding insurer to recognize credit for reinsurance.

(2) A United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program.

(3) A qualified jurisdiction, as determined by the

1 commissioner under section 319.1(a.2)(2) which is not otherwise
2 described under paragraph (1) or (2) and which the commissioner
3 determines meets all of the following additional requirements:
4 (i) Provides that an insurer that has its head office or is
5 domiciled in the qualified jurisdiction shall receive credit for
6 reinsurance ceded to a United States-domiciled assuming insurer
7 in the same manner as credit for reinsurance is received for
8 reinsurance assumed by insurers domiciled in such qualified
9 jurisdictions.
10 (ii) Does not require a United States-domiciled assuming
11 insurer to establish or maintain a local presence as a condition
12 for entering into a reinsurance agreement with any ceding
13 insurer subject to regulation by the non-United States
14 jurisdiction or as a condition to allow the ceding insurer to
15 recognize credit for such reinsurance.
16 (iii) Recognizes the United States state regulatory approach
17 to group supervision and group capital by providing written
18 confirmation by a competent regulatory authority, in the
19 qualified jurisdiction, that insurers and insurance groups that
20 are domiciled or maintain their headquarters in this
21 Commonwealth or another jurisdiction accredited by the National
22 Association of Insurance Commissioners shall be subject only to
23 worldwide prudential insurance group supervision including
24 worldwide group governance, solvency and capital and reporting,
25 as applicable, by the commissioner or the commissioner of the
26 domiciliary state and will not be subject to group supervision
27 at the level of worldwide parent undertaking of the insurance or
28 reinsurance group by the qualified jurisdiction.
29 (iv) Provides written confirmation by a competent regulatory
30 authority in the qualified jurisdiction that information

1 regarding insurers and their parent, subsidiary or affiliated
2 entities, if applicable, shall be provided to the commissioner
3 in accordance with a memorandum of understanding or similar
4 document between the commissioner and such qualified
5 jurisdiction, including, but not limited to, the international
6 association of insurance supervisors multilateral memorandum of
7 understanding or multilateral memoranda of understanding
8 coordinated by the National Association of Insurance
9 Commissioners.
10 Section 1.2. Sections 1701, 1702, 1703, 1704(a), 1705(a),
11 1706 and 1707 of the act are amended to read:
12 Section 1701. Purpose.--The purpose of this article is to
13 protect, subject to certain limitations, the persons specified
14 in section 1703(a) against failure in the performance of
15 contractual obligations, under life [and], health [insurance
16 policies] and annuity policies, plans or contracts specified in
17 section 1703(b), because of the impairment or insolvency of the
18 member insurer that issued the policies, plans or contracts. To
19 provide this protection, an association of member insurers is
20 created to pay benefits and to continue coverages as limited
21 herein, and [members] member insurers of the association are
22 subject to assessment to provide funds to carry out the purpose
23 of this article.
24 Section 1702. Definitions.--As used in this article the
25 following words and phrases shall have the meanings given to
26 them in this section:
27 "Account." [Any] Either of the two accounts created under
28 section 1704.
29 "Association." The Pennsylvania Life and Health Insurance
30 Guaranty Association created under section 1704.

"Authorized assessment" or "authorized." The term 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.

"Benefit plan." A specific employee, union or association of natural persons benefit plan.

"Called assessment" or "called." The term 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 specified in the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Contractual obligation." Any obligation under a policy or contract or certificate under a group policy or contract or portion thereof for which coverage is provided under section 1703.

"Covered [policy."] policy" or "covered contract." Any policy or contract within the scope of this article under section 1703.

"Department." The Insurance Department of the Commonwealth.

"Employee Retirement Income Security Act of 1974" or "ERISA." The Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1001 et seq.).

"Extra contractual claims." The term shall include claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney costs and fees.

"Health benefit plan." Any hospital or medical expense policy or certificate, RANLI PPO policy or subscriber contract, hospital plan corporation, professional health services plan corporation or health maintenance organization subscriber contract or any other similar health contract. The term does not include:

(1) Accident only insurance.

(2) Credit insurance.

(3) Dental only insurance.

(4) Vision only insurance.

(5) Medicare supplement insurance.

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

(7) Disability income insurance.

(8) Coverage for on-site medical clinics.

(9) 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.

"Health maintenance organization." An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Hospital plan corporation." A not-for-profit corporation engaged in the business of maintaining and operating a nonprofit hospital plan as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

"Impaired insurer." A member insurer which, after the

1 effective date of this article, is not an insolvent insurer and:
2 (1) is deemed by the Insurance Commissioner to be
3 potentially unable to fulfill its contractual obligations; or
4 (2) is placed under an order of rehabilitation or
5 conservation by a court of competent jurisdiction.
6 "Insolvent insurer." A member insurer which, after the
7 effective date of this article, is placed under an order of
8 liquidation by a court of competent jurisdiction with a finding
9 of insolvency.
10 "Internal Revenue Code of 1986." The Internal Revenue Code
11 of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.).
12 "Member insurer." Any insurer, RANLI PPO, hospital plan
13 corporation, professional health services plan corporation or
14 health maintenance organization licensed or which holds a
15 certificate of authority to transact in this Commonwealth any
16 kind of insurance, RANLI PPO business, hospital plan corporation
17 business, professional health services plan corporation business
18 or health maintenance organization business for which coverage
19 is provided under section 1703 and includes any insurer, RANLI
20 PPO, hospital plan corporation, professional health services
21 plan corporation or health maintenance organization whose
22 license or certificate of authority in this Commonwealth may
23 have been suspended, revoked, not renewed or voluntarily
24 withdrawn. The term does not include any of the following:
25 [(1) A nonprofit hospital or medical service organization.
26 (2) A health maintenance organization.
27 (3)] (1) A fraternal benefit society.
28 [(4)] (2) A mandatory State pooling plan.
29 [(5)] (3) A mutual assessment company or any entity that
30 operates on an assessment basis.

[(6)] (4) An insurance exchange.

(5) An organization that is a qualified charity issuing only qualified charitable gift annuities exempt from regulation under the act of October 16, 1996 (P.L.712, No.127), known as the Charitable Gift Annuity Exemption Act.

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

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

"Owner." The owner of a policy or contract. The terms "policyholder," "contract holder" "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 member insurer. The terms "owner," "contract owner," "policy owner," "policyholder" and "contract holder" do not include persons with a mere beneficial interest in a policy or contract.

"Person." Any individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

"Plan sponsor." The term includes:

(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 that establish or maintain the benefit plan.

"Premium or income tax." The tax imposed under Article IV or IX of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Premiums." The amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon and less dividends and experience credits thereon. The term does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 1703(b) except that assessable premium shall not be reduced on account of sections 1703(b)(2)(iii) relating to interest limitations and 1703(c)(1)(ii) relating to limitations with respect to any one individual, any one participant and any one policy or contract holder. The term does not include any premiums in excess of five million ($5,000,000) dollars on any unallocated annuity contract not issued under a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.). The term does not include, with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million ($5,000,000) dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

"Principal place of business." The following apply:

(1) The 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 all the following factors:

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

(ii) The state in which the principal office of the chief executive officer of the entity is located.

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

(iv) 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 meetings.

(v) The state from which the management of the overall operations of the entity is directed.

(vi) 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 factors under subparagraphs (i), (ii), (iii), (iv), (v) and (vi).

(2) If, in the case of a plan sponsor, 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.

(3) The principal place of business of a plan sponsor of a benefit plan described in paragraph (3) under the definition of

1 plan sponsor in this section shall be deemed to be the principal
2 place of business of the association, committee, joint board of
3 trustees or other similar group of representatives of the
4 parties who establish or maintain the benefit plan that, in lieu
5 of a specific or clear designation of a principal place of
6 business, shall be deemed to be the principal place of business
7 of the employer or employee organization that has the largest
8 investment in the benefit plan in question.
9 "Professional health services plan corporation." A person
10 engaged in the business of maintaining and operating a nonprofit
11 health service plan as defined in 40 Pa.C.S. Ch. 63 (relating to
12 professional health services plan corporations).
13 "RANLI PPO." An entity not licensed as an insurance company
14 but assuming risk as defined in section 630.
15 "Receivership court." The court in the insolvent insurer's
16 or impaired insurer's state having jurisdiction over the
17 conservation, rehabilitation or liquidation of the member
18 insurer.
19 "Resident." Any person who resides in this Commonwealth at
20 the time a member insurer is determined to be an impaired or
21 insolvent insurer and to whom a contractual obligation is owed.
22 A person may be a resident of only one state, which, in the case
23 of a person other than a natural person, shall be its principal
24 place of business. Citizens of the United States who are
25 residents of foreign countries or residents of United States
26 possessions, territories or protectorates that do not have an
27 association similar to the association created by this article
28 shall be deemed residents of the state of domicile of the member
29 insurer that issued the policies or contracts.
30 "Structured settlement annuity." An annuity purchased in

1 order to fund periodic payments for a plaintiff or other
2 claimant in payment for or with respect to personal injury
3 suffered by the plaintiff or other claimant.
4 "State." A state, the District of Columbia, Puerto Rico,
5 and a United States possession, territory or protectorate.
6 "Supplemental contract." Any agreement entered into for the
7 distribution of policy or contract proceeds.
8 "Unallocated annuity contract." Any annuity contract or
9 group annuity certificate which is not issued to and owned by an
10 individual, except to the extent of any annuity benefits
11 guaranteed to an individual by an insurer under such contract or
12 certificate.
13 Section 1703. Coverage and Limitations.--(a) This article
14 shall provide coverage to the following persons for the policies
15 and contracts specified in subsection (b):
16 (1) To persons who, regardless of where they reside, except
17 for nonresident certificate holders or enrollees under group
18 policies or contracts, are the beneficiaries, assignees or
19 payees, including health care providers rendering services
20 covered under health insurance policies or certificates of the
21 persons covered under paragraph (2).
22 (2) To persons who are owners of or certificate holders or
23 enrollees under these policies or contracts [or, in the case
24 of], other than unallocated annuity contracts[, to the persons
25 who are the contract holders] and structured settlement
26 annuities, and who:
27 (i) are residents; or
28 (ii) are not residents, but only under all of the following
29 conditions:
30 (A) the [insurers which] member insurer that issued such

policies or contracts [are] is domiciled in this Commonwealth;

(B) [such insurers never held a license or certificate of authority in the states in which such persons reside;] the states in which the persons reside have associations similar to the association created by this article; and

[(C) these states have associations similar to the association created by this article; and

(D) these] (C) the persons are not eligible for coverage by [those associations.] associations in any other state due to the fact that such insurers, RANLI PPOs, hospital plan corporations, professional health services plan corporations, or health maintenance organizations were not licensed or did not hold a certificate of authority in the states in which the persons reside at the time specified in the state's guaranty association law.

(3) For unallocated annuity contracts specified in subsection (b), paragraphs (1) and (2) shall not apply, and this article shall, except as provided in paragraphs (5) and (6), provide coverage to:

(i) 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 Commonwealth.

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

(4) For structured settlement annuities specified in subsection (b), paragraphs (1) and (2) shall not apply, and this article shall, except as provided in paragraphs (5) and (6), provide coverage to a person who is a payee under a structured

settlement annuity or beneficiary of a payee if the payee is deceased, if the payee:

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

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

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

(II) the contract owner of the structured settlement annuity is not a resident; but

(a) the member insurer that issued the structured settlement annuity is domiciled in this Commonwealth; and

(b) the state in which the contract owner resides has an association similar to the association created by this article; and

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

(5) This article shall not provide coverage to:

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

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

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

1 became effective.

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

14 (b) (1) This article shall provide coverage to the persons
15 specified in subsection (a) for policies or contracts of direct,
16 nongroup life insurance, health[, annuity] insurance, which for
17 the purposes of this article includes, RANLI PPO, hospital plan
18 corporation, professional health services plan corporation and
19 health maintenance organization subscriber policies, contracts,
20 and certificates, or annuities and supplemental [policies or]
21 contracts to any of these, for certificates under direct group
22 policies and contracts and for unallocated annuity contracts
23 issued by member insurers, except as limited by this article.
24 Annuity contracts and certificates under group annuity contracts
25 include, but are not limited to, guaranteed investment
26 contracts, deposit administration contracts, unallocated funding
27 agreements, allocated funding agreements, structured settlement
28 [agreements, lottery contracts] annuities, annuities issued to
29 or in connection with government lotteries and any immediate or
30 deferred annuity contracts.

(2) [This] Except as otherwise provided in paragraph (3), this article shall not provide coverage for any of the following:

(i) 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 holder.

(ii) Any policy or contract of reinsurance, unless assumption certificates have been issued.

(iii) 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:

(A) averaged over the period of four (4) years prior to the date on which the [association] member insurer becomes [obligated with respect to such policy or contract] an impaired or insolvent insurer under this article, whichever is earlier, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for the same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the [association became obligated] member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier; and

(B) on and after the date on which the [association] member insurer becomes [obligated with respect to such policy or contract] an impaired or insolvent insurer under this article, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available.

1 (iv) Any portion of a policy or contract issued to a plan or
2 program of an employer, association or similar entity to provide
3 life, health or annuity benefits to its [employes or] employees,
4 members or others to the extent that such plan or program is
5 self-funded or uninsured, including, but not limited to,
6 benefits payable by an employer, association or similar entity
7 under:
8 (A) a Multiple Employer Welfare Arrangement as defined in
9 section [514] 3(40) of the Employee Retirement Income Security
10 Act of 1974 (Public Law 93-406, 29 U.S.C. § 1002(40));
11 (B) a minimum premium group insurance plan;
12 (C) a stop-loss group insurance plan; or
13 (D) an administrative services only contract.
14 (v) Any portion of a policy or contract to the extent that
15 it provides dividends or experience rating credits [or provides
16 that], voting rights or for the payment of any fees or
17 allowances [to be paid] to any person, including the
18 policyholder or contract holder, in connection with the service
19 to or administration of such policy or contract.
20 (vi) Any policy or contract issued in this Commonwealth by a
21 member insurer at a time when it was not licensed or did not
22 have a certificate of authority to issue such policy or contract
23 in this Commonwealth.
24 (vii) Any unallocated annuity contract issued to an
25 [employe] employee benefit plan protected under the Federal
26 Pension Benefit Guaranty Corporation[.], regardless of whether
27 the Federal Pension Benefit Guaranty Corporation has yet become
28 liable to make any payments with respect to the benefit plan.
29 (viii) Any portion of any unallocated annuity contract which
30 is not issued to or in connection with a specific [employe]

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

(ix) A portion of a policy or contract to the extent that the assessments required by section 1707 with respect to the policy or contract are preempted by Federal or State law.

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

(A) claims based on marketing materials;

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

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

(D) extracontractual claims; or

(E) a claim for penalties or consequential or incidental damages.

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

(xii) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract

owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this article, 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 subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

(xiii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits under Part C or Part D of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C. § 1395 et seq.), Title XIX of the Social Security Act (Public Law 74-271, 42 U.S.C. § 1396 et seq.), Article XXIII-A or any regulations issued pursuant thereto.

(xiv) 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) (relating to the taxation of structured settlement factoring transactions), regardless of whether the transaction occurred before or after the section became effective.

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

(c) (1) The benefits for which the association may become liable shall in no event exceed the lesser of:

1 (i) the contractual obligations for which the member insurer
2 is liable or would have been liable if it were not an impaired
3 or insolvent insurer; or
4 (ii) (A) With respect to any one life, regardless of the
5 number of policies or contracts, the following shall apply:
6 (I) Three hundred thousand ($300,000) dollars [in] for life
7 insurance death benefits, but not more than one hundred thousand
8 ($100,000) dollars in net cash surrender and net cash withdrawal
9 values for life insurance.
10 [(II) Three hundred thousand ($300,000) dollars in health
11 insurance benefits, including any net cash surrender and net
12 cash withdrawal values.
13 (III) Three hundred thousand ($300,000) dollars in annuity
14 benefits, including one hundred thousand ($100,000) dollars in
15 net cash surrender and net cash withdrawal values.
16 (IV) Three hundred thousand ($300,000) dollars in long-term
17 care insurance benefits, as defined under section 1103,
18 including any cash surrender and net cash withdrawal values.]
19 (II) For health insurance benefits:
20 (1) One hundred thousand ($100,000) dollars for coverages or
21 benefits not defined as disability income insurance as defined
22 by 31 Pa. Code § 88.167 (relating to disability income
23 protection coverage), health benefit plans as defined by section
24 1702 of this article or long-term care insurance as defined in
25 section 1103, including any net cash surrender and net cash
26 withdrawal values.
27 (2) Three hundred thousand ($300,000) dollars for disability
28 income insurance, as defined by 31 Pa. Code § 88.167, and long-
29 term care insurance benefits as defined under section 1103,
30 including any cash surrender and net cash withdrawal values.

1 (3) Five hundred thousand ($500,000) dollars for health
2 benefit plans.
3 (III) Two hundred fifty thousand ($250,000) dollars in the
4 present value of annuity benefits, including net cash surrender
5 and net cash withdrawal values.
6 (B) With respect to each individual participating in a
7 governmental retirement plan established under section 401,
8 403(b) or 457 of the Internal Revenue Code of 1986 covered by an
9 unallocated annuity contract or the beneficiaries of each such
10 individual if deceased, in the aggregate, [three hundred
11 thousand ($300,000)] two hundred fifty thousand ($250,000)
12 dollars in [annuity benefits, including one hundred thousand
13 ($100,000) dollars in] present value annuity benefits, including
14 net cash surrender and net cash withdrawal values.
15 (C) With respect to each payee of a structured settlement
16 annuity, or beneficiary or beneficiaries of the payee if
17 deceased, two hundred fifty thousand ($250,000) dollars in
18 present value annuity benefits, in the aggregate, including net
19 cash surrender and net cash withdrawal values, if any.
20 [(C)] (D) With respect to [any] either one contract [holder
21 covered by any] owner provided coverage under subsection (a)(3)
22 (ii) or one plan sponsor whose plans own directly or in trust
23 one or more unallocated annuity [contract] contracts not
24 included in clause (B), five million ($5,000,000) dollars in
25 benefits, irrespective of the number of such contracts held by
26 that contract [holder.] owner or plan sponsor. In the case where
27 one or more unallocated annuity contracts are covered contracts
28 under this article and are owned by a trust or other entity for
29 the benefit of two (2) or more plan sponsors, coverage shall be
30 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 Commonwealth and in no event shall the association be obligated to cover more than five million ($5,000,000) dollars in benefits with respect to all these unallocated contracts.

[(2)] (E) The association shall not, however, be liable to expend more than three hundred thousand ($300,000) dollars in the aggregate with respect to any one individual under subparagraph (ii)(A) [and (B)], (B) or (C) of paragraph (1)[.] , except with respect to benefits for health benefit plans under subclause (II)(3) of clause (A), in which case the aggregate liability of the association shall not exceed five hundred thousand ($500,000) dollars with respect to any one individual, or with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million ($5,000,000) dollars in benefits, regardless of the number of policies and contracts held by the owner.

(F) The limitations specified in this section are limitations on the benefits for which the association is obligated before taking into account either the association's 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 article may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to the association's subrogation and assignment rights.

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

(d) In performing its obligations to provide coverage under section 1706, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy, that do not materially affect the economic values or economic benefits of the covered policy.

Section 1704. Creation of Association.--(a) There is hereby created a nonprofit, unincorporated association to be known as the Pennsylvania Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their license or authority to transact insurance, RANLI PPO business, hospital plan corporation business, professional health services plan corporation business or health maintenance organization business in this Commonwealth. The association shall perform its functions under the plan of operation established and approved under section 1708 and shall exercise its powers through a board of directors established under section 1705. For purposes of administration and assessment the association shall maintain two accounts:

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

(i) Life insurance account.

(ii) Annuity account[.], which shall include annuity

1 contracts owned by a governmental retirement plan or its trustee
2 established under section 401, 403(b) or 457 of the Internal
3 Revenue Code of 1986, but shall otherwise exclude unallocated
4 annuities.
5 (iii) Unallocated annuity account which shall [include]
6 exclude contracts [qualified under section] owned by a
7 governmental retirement benefit plan or its trustee under
8 section 401, 403(b) or 457 of the Internal Revenue Code of 1986.
9 (2) The health [insurance] account.
10 * * *
11 Section 1705. Board of Directors.--(a) The board of
12 directors of the association shall consist of not less than
13 [five (5)] seven (7) nor more than [nine (9)] eleven (11) member
14 insurers serving terms as established in the plan of operation.
15 The members of the board shall be selected by member insurers
16 subject to the approval of the commissioner. Vacancies on the
17 board shall be filled for the remaining period of the term by a
18 majority vote of the remaining board members, subject to the
19 approval of the commissioner. To select the initial board of
20 directors and initially organize the association, the
21 commissioner shall give notice to all member insurers of the
22 time and place of the organizational meeting. In determining
23 voting rights at the organizational meeting, each member insurer
24 shall be entitled to one (1) vote in person or by proxy. If the
25 board of directors is not selected within sixty (60) days after
26 notice of the organizational meeting, the commissioner may
27 appoint the initial members.
28 * * *
29 Section 1706. Powers and Duties of Association.--(a) If a
30 member insurer is an impaired [domestic] insurer, the

1 association may, in its discretion and subject to any conditions
2 imposed by the association that do not impair the contractual
3 obligations of the impaired insurer that are approved by the
4 commissioner [and that are, except in cases of court-ordered
5 conservation or rehabilitation, also approved by the impaired
6 insurer]:
7 (1) guarantee, assume, reissue or reinsure or cause to be
8 guaranteed, assumed, reissued or reinsured any or all of the
9 policies or contracts of the impaired insurer; or
10 (2) provide such moneys, pledges, notes, guarantees or other
11 means as are proper to effectuate paragraph (1) and assure
12 payment of the contractual obligations of the impaired insurer
13 pending action under paragraph (1).[; or
14 (3) loan money to the impaired insurer.
15 (b) (1) If a member insurer is an impaired insurer, whether
16 domestic, foreign or alien, and the insurer is not paying claims
17 timely, then subject to the preconditions specified in paragraph
18 (2), the association shall, in its discretion, either:
19 (i) take any of the actions specified in subsection (a),
20 subject to the conditions therein; or
21 (ii) provide substitute benefits in lieu of the contractual
22 obligations of the impaired insurer solely for health claims,
23 periodic annuity benefit payments, death benefits, supplemental
24 benefits and cash withdrawals for policy or contract owners who
25 petition therefor under claims of emergency or hardship in
26 accordance with standards proposed by the association and
27 approved by the commissioner.
28 (2) The association shall be subject to the requirements of
29 paragraph (1) only if:
30 (i) the laws of its state of domicile provide that until all

payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(A) the delinquency proceeding shall not be dismissed;

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

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

(ii) in the case where the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this Commonwealth; or

(iii) in the case where the impaired insurer is a foreign or alien insurer, it has been prohibited from soliciting or accepting new business in this Commonwealth, its certificate of authority has been suspended or revoked in this Commonwealth, and a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.]

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

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

[(2)] (ii) assure payment of the contractual obligations of the insolvent insurer and provide such moneys, pledges, guarantees or other means as are reasonably necessary to

discharge such duties; or

[(3) with respect only to life and health insurance policies, provide] (2) Provide benefits and coverages in accordance with [subsection (d).

(d) (1) When proceeding under subsection (b)(1)(ii) or (c)(3), the association shall, with respect to only life and health insurance policies, do all of the following:] the following provisions:

(i) [Assure] With respect to policies and contracts, assure payment of benefits [for premiums identical to the premiums and benefits (except for terms of conversion and renewability)] that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred as follows:

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

(B) With respect to [individual] nongroup policies and contracts and annuities, not later than the earlier of the next renewal date (if any) under such 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 such policies or contracts.

(ii) Make diligent efforts to provide all known insureds, enrollees, annuitants or group policyholders or contract holders with respect to group policies or contracts thirty (30) days notice of the termination of the benefits provided.

(iii) With respect to [individual] nongroup policies and contracts, make available to each known insured, enrollee,

1 annuitant or owner if other than the insured, enrollee or
2 annuitant and with respect to an individual formerly an insured,
3 enrollee or annuitant under a group policy or contract who is
4 not eligible for replacement group coverage, make available
5 substitute coverage on an individual basis in accordance with
6 the provisions of [paragraph (2)] subparagraph (iv), if the
7 insureds, enrollees or annuitants had a right under law or the
8 terminated policy, contract or annuity to convert coverage to
9 individual coverage or to continue an individual policy,
10 contract or annuity in force until a specified age or for a
11 specified time, during which the insurer, RANLI PPO, hospital
12 plan corporation, professional health services plan corporation
13 or health maintenance organization had no right unilaterally to
14 make changes in any provision of the policy, contract or annuity
15 or had a right only to make changes in premium by class.
16 [(2) (i)] (iv) (A) (I) In providing the substitute
17 coverage required under [paragraph (1)(iii)] subparagraph (iii),
18 the association may offer either to reissue the terminated
19 coverage or to issue an alternative policy[.] or contract at
20 actuarially justified rates subject to prior approval of the
21 commissioner.
22 [(ii)] (II) Alternative or reissued policies or contracts
23 shall be offered without requiring evidence of insurability and
24 shall not provide for any waiting period or exclusion that would
25 not have applied under the terminated policy or contract.
26 [(iii)] (III) The association may reinsure any alternative
27 or reissued policy or contract.
28 [(3) (i)] (B) (I) Alternative policies or contracts
29 adopted by the association shall be subject to the approval of
30 the commissioner. The association may adopt alternative policies

1 or contracts of various types for future issuance without regard
2 to any particular impairment or insolvency.
3 [(ii)] (II) Alternative policies or contracts shall contain
4 at least the minimum statutory provisions required in this
5 Commonwealth and provide benefits that shall not be unreasonable
6 in relation to the premium charged. The association shall set
7 the premium in accordance with a table of rates which it shall
8 adopt. The premium shall reflect the amount of insurance to be
9 provided and the age and class of risk of each insured, but
10 shall not reflect any changes in the health of the insured after
11 the original policy or contract was last underwritten.
12 [(iii)] (III) Any alternative policy or contract issued by
13 the association shall provide coverage of a type similar to that
14 of the policy or contract issued by the impaired or insolvent
15 insurer, as determined by the association.
16 [(4)] (v) If the association elects to reissue terminated
17 coverage at a premium rate different from that charged under the
18 terminated policy or contract, the premium shall be actuarially
19 justified and set by the association in accordance with the
20 amount of insurance or coverage provided and the age and class
21 of risk, subject to approval of the commissioner [or by a court
22 of competent jurisdiction].
23 [(5)] (vi) The association's obligations with respect to
24 coverage under any policy or contract of the impaired or
25 insolvent insurer or under any reissued or alternative policy or
26 contract shall cease on the date such coverage or policy or
27 contract is replaced by another similar policy or contract by
28 the policyholder, contract holder, the insured, the enrollee or
29 the association.
30 [(e)] (c) When proceeding under subsection [(b)(1)(ii) or

1 (c)] (b)(2) with respect to any policy or contract carrying
2 guaranteed minimum interest rates, the association shall assure
3 the payment or crediting of a rate of interest consistent with
4 section 1703(b)(2)(iii).
5 [(f)] (d) Nonpayment of premiums within thirty-one (31) days
6 after the date required under the terms of any guaranteed,
7 assumed, alternative or reissued policy or contract or
8 substitute coverage shall terminate the association's
9 obligations under such policy, contract or coverage under this
10 article with respect to such policy, contract or coverage,
11 except with respect to any claims incurred or any net cash
12 surrender value which may be due in accordance with the
13 provisions of this article.
14 [(g)] (e) Premiums due for coverage after entry of an order
15 of liquidation of an insolvent insurer shall belong to and be
16 payable at the direction of the association, and the association
17 shall be liable for unearned premiums due to policy or contract
18 owners arising after the entry of such order.
19 [(h)] (f) The protection provided by this article shall not
20 apply where any guaranty protection is provided to residents of
21 this Commonwealth by the laws of the domiciliary state or
22 jurisdiction of the impaired or insolvent insurer other than
23 this Commonwealth.
24 [(i)] (g) In carrying out its duties under [subsections (b)
25 and (c)] subsection (b) and subject to approval by the court,
26 the association may do the following:
27 (1) Impose permanent policy or contract liens in connection
28 with any guarantee, assumption or reinsurance agreement if the
29 association finds that the amounts which can be assessed under
30 this article are less than the amounts needed to assure full and

prompt performance of the association's duties under this [act] article or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest.

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

(h) A deposit in this Commonwealth, 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 a member insurer domiciled in this Commonwealth or in a reciprocal State, pursuant to Article IV of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, 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 Commonwealth related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable Commonwealth receivership law dealing with early access disbursements.

[(j)] (i) If the association fails to act within a reasonable period of time as provided in [subsections (b)(1)(ii), (c) and (d)] subsection (b), the commissioner shall have the powers and duties of the association under this article with respect to impaired or insolvent insurers.

[(k)] (j) The association may render assistance and advice to the commissioner, upon [his] the request of the commissioner, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of any impaired or insolvent insurer.

[(l)] (k) The association shall have standing to appear or intervene before any court or agency in this Commonwealth with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this article. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or

1 insolvent insurer and the determination of the policies or
2 contracts and contractual obligations. The association shall
3 also have the right to appear or intervene before a court or
4 agency in another state with jurisdiction over an impaired or
5 insolvent insurer for which the association is or may become
6 obligated or with jurisdiction over [a third party] any person
7 or property against whom the association may have rights through
8 subrogation [of the insurer's policyholders] or otherwise.
9 [(m)] (l) (1) Any person receiving benefits under this
10 article shall be deemed to have assigned the rights under and
11 any causes of action relating to the covered policy or contract
12 to the association to the extent of the benefits received
13 because of this article, whether the benefits are payments of or
14 on account of contractual obligations, continuation of coverage
15 or provision of substitute or alternative policies, contracts or
16 coverages. The association may require an assignment to it of
17 such rights and cause of action by any payee, policy or contract
18 owner, beneficiary, insured, enrollee or annuitant as a
19 condition precedent to the receipt of any rights or benefits
20 conferred by this article upon such person.
21 (2) The subrogation rights of the association under this
22 subsection shall have the same priority against the assets of
23 the impaired or insolvent insurer as that possessed by the
24 person entitled to receive benefits under this article.
25 (3) In addition to paragraphs (1) and (2), the association
26 shall have all common law rights of subrogation and any other
27 equitable or legal remedy which would have been available to the
28 impaired or insolvent insurer or owner or holder, beneficiary,
29 enrollee or payee of a policy or contract with respect to such
30 policy or contracts[.] (including without limitation, in the

case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore), excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code of 1986.

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

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in paragraphs (1), (2), (3) and (4) the person shall pay to the association the portion of the recovery attributable to the policies or contracts (or portion thereof) covered by the association.

[(n) The] (m) In addition to the rights and powers elsewhere in this article, the association may do the following:

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

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 1707 and to settle claims or potential claims against it.

(3) Borrow money to effect the purposes of this article; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers or member insurers and may be carried as admitted assets.

(4) Employ or retain such persons as are necessary to handle the financial transactions of the association and perform such other functions as become necessary or proper under this article.

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

(6) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life [or] insurer, health insurer, RANLI PPO, hospital plan corporation, professional health services plan corporation 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 article.

(7) Organize itself as a corporation or in other legal form permitted by the laws of this Commonwealth.

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

(9) 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 article.

(10) Take other necessary or appropriate action to discharge its duties and obligations under this article or to exercise its

1 powers under this article.

2 [(o)] (n) The association may join an organization of one or
3 more other state associations of similar purposes, to further
4 the purposes and administer the powers and duties of the
5 association.

6 (o) (1) (i) At any time within one hundred eighty (180)
7 days of the date of the order of liquidation, the association
8 may elect to succeed to the rights and obligations of the ceding
9 member insurer that relate to policies, contracts, or annuities
10 covered, in whole or in part, by the association, in each case
11 under any one or more reinsurance contracts entered into by the
12 insolvent insurer and its reinsurers and selected by the
13 association. Any such assumption shall be effective as of the
14 date of the order of liquidation. The election shall be effected
15 by the association or the National Organization of Life and
16 Health Insurance Guaranty Associations (NOLHGA) on its behalf
17 sending written notice, return receipt requested, to the
18 affected reinsurers.

19 (ii) To facilitate the earliest practicable decision about
20 whether to assume any of the contracts of reinsurance, and in
21 order to protect the financial position of the estate, the
22 receiver and each reinsurer of the ceding member insurer shall
23 make available upon request to the association or to NOLHGA on
24 its behalf as soon as possible after commencement of formal
25 delinquency proceedings (A) copies of in-force contracts of
26 reinsurance and all related files and records relevant to the
27 determination of whether such contracts should be assumed, and
28 (B) notices of any defaults under the reinsurance contacts or
29 any known event or condition which with the passage of time
30 could become a default under the reinsurance contracts.

(iii) The following clauses 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, contracts or annuities covered, in whole or in part, by the association. The association may charge 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 amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered, in whole or in part, by the association, provided that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(I) The amount received by the association; and

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

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

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

amounts due from parties other than the association, against amounts due the association.

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

(i) (A) 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 (1), whether for periods prior to or after the date of the order of liquidation; and

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

(ii) provided that once the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by paragraph (1).

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

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

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

1 addition to those transferred.
2 (ii) The obligations described in paragraph (1) shall no
3 longer apply with respect to matters arising after the effective
4 date of the transfer.
5 (iii) Notice shall be given in writing, return receipt
6 requested, by the transferring party to the affected reinsurer
7 not less than thirty (30) days prior to the effective date of
8 the transfer.
9 (5) The provisions of this subsection shall supersede the
10 provisions of any state law or of any affected reinsurance
11 contract that provides for or requires any payment of
12 reinsurance proceeds, on account of losses or events that occur
13 in periods after the date of the order of liquidation, to the
14 receiver of the insolvent insurer or any other person. The
15 receiver shall remain entitled to any amounts payable by the
16 reinsurer under the reinsurance contracts with respect to losses
17 or events that occur in periods prior to the date of the order
18 of liquidation, subject to applicable setoff provisions.
19 (6) Except as otherwise provided in this section, nothing in
20 this subsection shall alter or modify the terms and conditions
21 of any reinsurance contract. Nothing in this section shall
22 abrogate or limit any rights of any reinsurer to claim that it
23 is entitled to rescind a reinsurance contract. Nothing in this
24 section shall give a policyholder, contract owner, enrollee,
25 certificate holder, or beneficiary an independent cause of
26 action against a reinsurer that is not otherwise set forth in
27 the reinsurance contract. Nothing in this section shall limit or
28 affect the association's rights as a creditor of the estate
29 against the assets of the estate. Nothing in this section shall
30 apply to reinsurance agreements covering property or casualty

risks.

(7) For the purposes of this subsection, "election date" shall mean the date of the association's election to succeed to the rights and obligations of a ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association.

(p) 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 article in an economical and efficient manner.

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

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

(s) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsection (a) or (b), the association may 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;

(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.

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

Section 1707. Assessments.--(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight per centum (8%) per annum on and after the due date.

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

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses [and examinations conducted under the authority of section 1710(e)]. Class A assessments may be [made] authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be [made] authorized and

called to the extent necessary to carry out the powers and duties of the association under section 1706 with regard to an impaired or an insolvent insurer.

(c) (1) The amount of any Class A assessment shall be determined by the board and may be [made] authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. [A non-pro rata assessment shall not exceed two hundred ($200) dollars per member insurer in any one calendar year.] The amount of [any] a Class B assessment, except for assessments related 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 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 the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for 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) For the purposes of the methodology in paragraph (2) and the formula in the plan of operation only, a "life and annuity member insurer" means a member insurer for which (i) the sum of its assessable life insurance premiums and annuity premiums is greater than or equal to (ii) its assessable health insurance premiums, which shall include its assessable RANLI PPO, hospital

plan corporation, professional health services plan corporation and health maintenance organization premiums, but shall exclude its assessable premiums written for disability income and long-term care insurance. For purposes of this definition, assessable premiums shall be measured within the Commonwealth. An "accident and health member insurer" means any member insurer not defined as a "life and annuity member insurer."

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

[(3)] (5) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be [made] authorized or called until necessary to implement the purposes of this article. Classification of assessments under subsection (b) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of the member insurer's anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days

1 after the assessment is authorized.
2 (d) The association may abate or defer, in whole or in part,
3 the assessment of a member insurer if, in the opinion of the
4 board, payment of the assessment would endanger the ability of
5 the member insurer to fulfill its contractual obligations. In
6 the event an assessment against a member insurer is abated, or
7 deferred in whole or in part, the amount by which such
8 assessment is abated or deferred may be assessed against the
9 other member insurers in a manner consistent with the basis for
10 assessments set forth in this section. Once the conditions that
11 caused a deferral have been removed or rectified, the member
12 insurer shall pay all assessments that were deferred pursuant to
13 a repayment plan approved by the association.
14 (e) (1) [The] (i) Subject to the provisions of
15 subparagraph (ii), the total of all assessments [upon a]
16 authorized by the association with respect to a member insurer
17 [for the life and annuity account and] for each subaccount
18 [thereunder] of the life insurance and annuity account and for
19 the health account shall not in any one (1) calendar year exceed
20 two per centum (2%) [and for the health account shall not in any
21 one (1) calendar year exceed two per centum (2%) of such] of
22 that member insurer's average annual premiums received in this
23 Commonwealth on the policies and contracts covered by the
24 subaccount or account during the three (3) calendar years
25 preceding the year in which the member insurer became an
26 impaired or insolvent insurer. [If the maximum assessment,
27 together with the other assets of the association in any
28 account, does not provide in any one (1) year in either account
29 an amount sufficient to carry out the responsibilities of the
30 association, the necessary additional funds shall be assessed as

soon thereafter as permitted by this article.]

(ii) If two (2) or more assessments are authorized in one (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 subparagraph (i) shall be equal and limited to the higher of the three (3) year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one (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 article.

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

(3) [If a one per centum (1%) assessment for any subaccount of the life and annuity account in any one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (c)(2), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (e)(1).] If the maximum assessment for a subaccount of the life and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (c)(2), the board shall access the other subaccounts of the life

and annuity account for the necessary additional amount, subject to the maximum stated in paragraph (1).

(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 and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(g) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance, RANLI PPO business, hospital plan corporation business, professional health services plan corporation business or health maintenance organization business within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article, provided that such member insurer has not elected to take tax credits as provided in section 1711(a).

(h) The association shall issue to each member insurer paying an assessment under this article, other than class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the 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.

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

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

Section 2. Section 1708(c) introductory paragraph and (d) of the act are amended and subsection (c) is amended by adding paragraphs to read:

Section 1708. Plan of Operation.--* * *

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this article[, contain the following]:

* * *

(8) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer.

(9) Require the board of directors to establish a policy and procedures for addressing conflicts of interests.

(d) The plan of operation may provide that any or all powers and duties of the association, except those under sections [1706(n)(3)] 1706(m)(3) and 1707, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association or its equivalent in two or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

1 Section 3. Sections 1709, 1710, 1711, 1712, 1713, 1715,
2 1716, 1717 and 1718 of the act are amended to read:
3 Section 1709. Powers and Duties of the Commissioner.--(a)
4 In addition to the powers and duties enumerated elsewhere in
5 this article, the commissioner shall:
6 (1) Upon request of the board of directors, provide the
7 association with a statement of the premiums in this and any
8 other appropriate states for each member insurer.
9 (2) When an impairment is declared and the amount of the
10 impairment is determined, serve a demand upon the impaired
11 insurer to make good the impairment within a reasonable time;
12 notice to the impaired insurer shall constitute notice to its
13 shareholders, if any; the failure of the impaired insurer to
14 promptly comply with such demand shall not excuse the
15 association from the performance of its powers and duties under
16 this article.
17 [(3) In any liquidation or rehabilitation proceeding
18 involving a domestic insurer, be appointed as the liquidator or
19 rehabilitator.]
20 (b) The commissioner may suspend or revoke, after notice and
21 hearing, the license or certificate of authority to transact
22 [insurance] business in this Commonwealth of any member insurer
23 which fails to pay an assessment when due or fails to comply
24 with the plan of operation. As an alternative, the commissioner
25 may levy a forfeiture on any member insurer which fails to pay
26 an assessment when due. Such forfeiture shall not exceed five
27 per centum (5%) of the unpaid assessment per month, but no
28 forfeiture shall be less than one hundred ($100) dollars per
29 month.
30 (c) Any final action of the board of directors or the

1 association may be appealed to the commissioner by any member
2 insurer if such appeal is taken within sixty (60) days of its
3 receipt of notice of the final action being appealed. [If a
4 member company is appealing an assessment, the amount assessed
5 shall be paid to the association and available to meet
6 association obligations during the pendency of an appeal. If the
7 appeal on the assessment is upheld, the amount paid in error or
8 excess shall be returned to the member company.] Any final
9 action or order of the commissioner shall be subject to judicial
10 review in a court of competent jurisdiction[.] in accordance
11 with the laws of this Commonwealth that apply to the actions or
12 orders of the commissioner.
13 (d) The liquidator, rehabilitator or conservator of any
14 impaired or insolvent insurer may notify all interested persons
15 of the effect of this article.
16 Section 1710. Prevention of Insolvencies.--(a) To aid in
17 the detection and prevention of member insurer insolvencies or
18 impairments, it shall be the duty of the commissioner:
19 (1) To notify the commissioners of all the other states,
20 territories of the United States and the District of Columbia
21 within thirty (30) days following the action taken or the date
22 the action occurs, when [he] the commissioner takes any of the
23 following actions against a member insurer:
24 (i) revocation of license or certificate of authority;
25 (ii) suspension of license or certificate of authority; or
26 (iii) makes any formal order that such [company] member
27 insurer restrict its premium writing, obtain additional
28 contributions to surplus, withdraw from the Commonwealth,
29 reinsure all or any part of its business or increase capital,
30 surplus or any other account for the security of [policyholders]

1 policy owners, contract owners, certificate holders or
2 creditors.
3 [This notice shall be mailed to all commissioners within thirty
4 (30) days following the action taken or the date on which such
5 action occurs.]
6 (2) To report to the board of directors when [he] the
7 commissioner has taken any of the actions set forth in paragraph
8 (1) or has received a report from any other commissioner
9 indicating that any such action has been taken in another state.
10 Such report to the board of directors shall contain all
11 significant details of the action taken or the report received
12 from another commissioner.
13 (3) To report to the board of directors when [he] the
14 commissioner has reasonable cause to believe from any
15 examination, whether completed or in process, of any member
16 [company] insurer that such [company] member insurer may be an
17 impaired or insolvent insurer.
18 (4) To furnish to the board of directors the National
19 Association of Insurance Commissioners' (NAIC) Insurance
20 Regulatory Information System (IRIS) ratios and listing of
21 companies not included in the ratios developed by the National
22 Association of Insurance Commissioners, and the board may use
23 the information contained therein in carrying out its duties and
24 responsibilities under this section. Such report and the
25 information contained therein shall be kept confidential by the
26 board of directors until such time as made public by the
27 commissioner or other lawful authority.
28 (b) The commissioner may seek the advice and recommendations
29 of the board of directors concerning any matter affecting [his]
30 the duties and responsibilities of the commissioner regarding

1 the financial condition of member insurers and [companies]
2 insurers, RANLI PPOs, hospital plan corporations, professional
3 health services plan corporations or health maintenance
4 organizations seeking admission to transact [insurance] business
5 in this Commonwealth.
6 (c) The board of directors may, upon majority vote, make
7 reports and recommendations to the commissioner upon any matter
8 germane to the solvency, liquidation, rehabilitation or
9 conservation of any member insurer or germane to the solvency of
10 any [company] insurers, RANLI PPOs, hospital plan corporations,
11 professional health services plan corporations or health
12 maintenance organizations seeking to do [an insurance] business
13 in this Commonwealth. Such reports and recommendations shall not
14 be considered public documents.
15 (d) [It shall be the duty of the] The board of directors
16 may, upon majority vote, [to] notify the commissioner of any
17 information indicating [any] a member insurer may be an impaired
18 or insolvent insurer.
19 [(e) (1) The board of directors may, upon majority vote,
20 request that the commissioner order an examination of any member
21 insurer which the board in good faith believes may be an
22 impaired or insolvent insurer. Within thirty (30) days of the
23 receipt of such request, the commissioner shall begin such
24 examination. The examination may be conducted as a National
25 Association of Insurance Commissioners examination or may be
26 conducted by such persons as the commissioner designates. The
27 cost of such examination shall be paid by the association, and
28 the examination report shall be treated as are other examination
29 reports. In no event shall such examination report be released
30 to the board of directors prior to its release to the public,

but this shall not preclude the commissioner from complying with subsection (a).

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

[(f)] (e) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

[(g) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of 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 of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.]

Section 1711. Credits for Assessments Paid.--(a) A member insurer may offset against its premium or income tax liability to this Commonwealth a proportionate part of the assessments described in section 1707 to the extent of twenty per centum (20%) of the amount of such assessment for each of the five (5) calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium or income tax liability for the year it ceases doing business.

(b) The proportionate part of an assessment which may be offset against a member [company's] insurer's premium or income

tax liability to the Commonwealth shall be determined according to a fraction of which the denominator is the total premiums (in the category assessed) received by the [company] member insurer during the calendar year immediately preceding the year in which the assessment is paid and the numerator is that portion of the premiums received during such year on account of policies or contracts of life insurance (including or limited to annuities and unallocated annuities per account or subaccount, as applicable per the assessment), or health and accident insurance (including RANLI PPO, hospital plan corporation, professional health services plan corporation and health maintenance organization subscriber policies, contracts and certificates), in which the premium rates are guaranteed during the continuance of the respective policies or contracts without a right exercisable by the [company] member insurer to increase said premium rates.

(c) A member insurer that is exempt from taxes referenced in subsection (a) may recoup its assessments by assigning available offsets (as calculated under subsection (b)) to a taxable member or members of its controlled group, as the term is defined under section 1563(a) of the Internal Revenue Code of 1986. Such assigned offsets may be utilized by the taxable member or members in the manner provided under subsection (a).

(d) A member insurer that is exempt from taxes referenced in subsection (a) and has no taxable members of a controlled group as referenced in subsection (c) may recoup its assessments by a surcharge on its premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the commissioner. Amounts recouped shall not be considered premiums for any other purpose, including the

1 computation of gross premium tax, the medical loss ratio or
2 agent commission. If a member insurer collects excess
3 surcharges, the member insurer shall remit the excess amount to
4 the association, and the excess amount shall be applied to
5 reduce future assessments in the appropriate account.
6 (e) Any sums which are acquired by refund, pursuant to
7 section 1707(f), from the association by member insurers, and
8 which have theretofore been offset against premium or income
9 taxes as provided in this section and are not then needed for
10 the purposes of this [act] article, shall be paid by such member
11 insurers to this Commonwealth in such manner as the tax
12 authorities may require. The association shall notify the
13 commissioner that such refunds have been made.
14 [(d)] (f) No offset against premium or income tax liability
15 shall be permitted to the extent that a member insurer's rates
16 or policyholder dividends have been adjusted as permitted in
17 section 1707.
18 Section 1712. Miscellaneous Provisions.--(a) Nothing in
19 this article shall be construed to reduce the liability for
20 unpaid assessments of the insureds of an impaired or insolvent
21 insurer operating under a plan with assessment liability.
22 (b) Records shall be kept of all [negotiations and] meetings
23 [in which the association or its representatives are involved]
24 of the board of directors to discuss the activities of the
25 association in carrying out its powers and duties under section
26 1706. [Records] The records of [such negotiations or meetings]
27 the association with respect to an impaired or insolvent insurer
28 shall [be made public only upon] not be disclosed prior to the
29 termination of a liquidation, rehabilitation or conservation
30 proceeding involving the impaired or insolvent insurer, except

(i) upon the termination of the impairment or insolvency of the member insurer, or (ii) upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under section 1713.

(c) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 1706. 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 article. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies 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) and consistent with section 536 of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, 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 article. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of 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.

[(d)] (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, contract owners, certificate holders, enrollees and [policyowners] policy owners of the insolvent insurer, and any other party with a bona 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] 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 with interest thereon for funds expended in carrying out its powers and duties under section 1706 with respect to such member insurer have been fully recovered by the association.

[(e)] (f) (1) If an order for liquidation or rehabilitation of [an] a member insurer domiciled in this Commonwealth 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 five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) to (4).

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

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

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

Section 1713. Examination of the Association and Annual Report.--The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than one hundred

1 twenty (120) days after the association's fiscal year, a
2 financial report in a form approved by the commissioner and a
3 report of its activities during the preceding fiscal year. Upon
4 the request of a member insurer, the association shall provide
5 the member insurer with a copy of the report.
6 Section 1715. Immunity.--There shall be no liability on the
7 part of and no cause of action of any nature shall arise against
8 any member insurer or its agents or [employes] employees, the
9 association or its agents or [employes] employees, members of
10 the board of directors or the commissioner or [his]
11 representatives of the commissioner for any action or omission
12 by them in the performance of their powers and duties under this
13 article. Such immunity shall extend to the participation in any
14 organization of one or more other state associations of similar
15 purposes and to any such organization and its agents or
16 [employes] employees.
17 Section 1716. Stay of Proceedings and Reopening Default
18 Judgments.--All proceedings in which the insolvent insurer is a
19 party in any court in this Commonwealth shall be stayed [sixty
20 (60)] one hundred eighty (180) days from the date an order of
21 liquidation, rehabilitation or conservation is final to permit
22 proper legal action by the association on any matters germane to
23 its powers or duties. As to judgment under any decision, order,
24 verdict or finding based on default, the association may apply
25 to have such judgment set aside by the same court that made such
26 judgment and shall be permitted to defend against such suit on
27 the merits.
28 Section 1717. Prohibited Advertisement [or] of Insurance
29 Guaranty Association [Act] Article in Insurance and Other
30 Coverage Sales.--(a) No person, including [an] a member

1 insurer, agent or affiliate of [an] a member insurer, shall
2 make, publish, disseminate, circulate or place before the
3 public, or cause, directly or indirectly, to be made, published,
4 disseminated, circulated or placed before the public, in any
5 newspaper, magazine or other publication, or in the form of a
6 notice, circular, pamphlet, letter or poster, or over any radio
7 station or television station, or in any other way, any
8 advertisement, announcement or statement, written or oral, which
9 uses the existence of the association for the purpose of sales,
10 solicitation or inducement to purchase any form of insurance or
11 other coverage covered by this article, provided, however, that
12 this section shall not apply to the association or any other
13 entity which does not sell or solicit insurance[.], or coverage
14 by a RANLI PPO, hospital plan corporation, professional health
15 services plan corporation or health maintenance organization.
16 (b) Within one hundred eighty (180) days of the effective
17 date of this article, the association shall prepare a summary
18 document describing the general purposes and current limitations
19 of the article and complying with subsection (c). This summary
20 document [should] shall be submitted to the commissioner for
21 approval. Sixty (60) days after receiving such approval, no
22 member insurer may deliver a policy or contract [described in
23 section 1703(b)(1)] to a [policyholder or contract holder]
24 policy owner, contract owner, certificate holder or enrollee
25 unless the summary document is delivered to the [policyholder or
26 contract holder] policy owner, contract owner, certificate
27 holder or enrollee prior to or at the time of delivery of the
28 policy or contract [except if subsection (d) applies]. The
29 summary document [should] shall also be available upon request
30 by a [policyholder] policy owner, contract owner, certificate

holder or enrollee. The distribution, delivery or contents or interpretation of [this] the summary document shall not mean that either the policy or the contract or the [holder] policy owner, contract owner, certificate holder or enrollee thereof would be covered in the event of the impairment or insolvency of a member insurer. The [description] summary document shall be revised by the association as amendments to the article may require. Failure to receive [this] the summary document does not give the [policyholder, contract holder,] policy owner, contract owner, certificate holder, enrollee or insured any greater rights than those stated in this article.

(c) The summary document prepared under subsection (b) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a regulation establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the association and department.

(2) Prominently warn the [policyholder or contract holder] policy owner, contract owner, certificate holder or enrollee that the association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this Commonwealth.

(3) State the types of policies or contracts for which guaranty funds will provide coverage.

[(3)] (4) State that the member insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance[.] or coverage by a RANLI PPO, hospital plan corporation, professional health services plan corporation

1 or health maintenance organization.

2 [(4)] (5) Emphasize that the [policyholder or contract
3 holder] policy owner, contract owner, certificate holder or
4 enrollee should not rely on coverage under the association when
5 selecting an insurer[.], RANLI PPO, hospital plan corporation,
6 professional health services plan corporation or health
7 maintenance organization.

8 (6) Explain rights available and procedures for filing a
9 complaint to allege a violation of any provisions of this
10 article.

11 [(5)] (7) Provide other information as directed by the
12 commissioner[.], including, but not limited to, sources for
13 information about the financial condition of insurers, RANLI
14 PPOs, hospital plan corporations, professional health services
15 plan corporations or health maintenance organizations provided
16 that the information is not proprietary and is subject to
17 disclosure under that state's public records law.

18 (d) [No insurer or agent may deliver a policy or contract
19 described in section 1703(b)(1) and excluded under section
20 1703(b)(2) from coverage under this article unless the insurer
21 or agent, prior to or at the time of delivery, gives the
22 policyholder or contract holder a separate written notice which
23 clearly and conspicuously discloses that the policy or contract
24 is not covered by the association. The commissioner shall by
25 regulation specify the form and content of the notice.] A member
26 insurer shall retain evidence of compliance with subsection (b)
27 for so long as the policy or contract for which the notice is
28 given remains in effect.

29 [Section 1718. Prospective Application.--This article shall
30 not apply to any insurer which was declared insolvent before the

1 effective date of this article.]

2 Section 4. The following shall apply:

3 (1) The amendment or addition of sections 1701, 1702,
4 1703, 1704(a), 1705(a), 1706, 1707, 1708(c) introductory
5 paragraph, (8) and (9) and (d), 1709, 1710, 1711, 1712, 1713,
6 1715, 1716, 1717 and 1718 of the act shall apply with respect
7 to a member insurer:

8 (i) that on or after the effective date of this
9 section is placed under an order of liquidation by a
10 court of competent jurisdiction with a finding of
11 insolvency; or

12 (ii) for which the association elects to exercise
13 its power and duties under section 1706(a) on or after
14 the effective date of this section.

15 (2) All matters relating to the insolvency or impairment
16 of any member insurer placed under an order of liquidation by
17 a court of competent jurisdiction with a finding of
18 insolvency before the effective date of this section, or for
19 which the association otherwise exercises its powers and
20 duties under section 1706(a) or (b) before the effective date
21 of this section, including past, present and future
22 assessments and credits, shall be governed by the provisions
23 of Article XVII in effect before the effective date of this
24 section.

25 Section 5. This act shall take effect immediately.