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

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2023

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A N A C T

RELATING TO INSURANCE -- PRODUCER LICENSING ACT

Introduced By: Representatives Kennedy, Azzinaro, Diaz, Ackerman, Casimiro, and Bennett
Date Introduced: March 01, 2023

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Sections 27-2.4-2 and 27-2.4-16 of the General Laws in Chapter 27-2.4 entitled "Producer Licensing Act" are hereby amended to read as follows:

27-2.4-2. Definitions.

The following definitions apply to this chapter:

(1) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity;

(2) ~~"Contracted producer report" means the annual report that all insurers contracting with insurance producers must provide to the department on or by March 1 listing each insurance producer to whom the insurer paid one hundred dollars ($100) or more in commissions for the preceding calendar year of January 1 to December 31. The department shall prescribe the form and manner of reporting.~~

(3) "Department" means the department of business regulation;

(4) "Home state" means any state or territory of the United States, or the District of Columbia, in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer;

(5) "Insurance" means any of the lines of authority set forth in this title;

(6) "Insurance commissioner" means the director of the department of business regulation or his or her designee;

(7) "Insurance producer" means a person required to be licensed under the laws of this state

to sell, solicit or negotiate insurance;

(8) "Insurer" means: (i) any person, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including insurance producers; (ii) notwithstanding §§ 27-19-2, 27-20-2, 27-20.1-2, 27-20.2-2, 27-20.3-2, and 27-41-22, all of whom shall be engaged in the business of insurance for the purpose of this chapter, nonprofit hospital and/or medical service corporation, a nonprofit dental service corporation, a nonprofit optometric service corporation, a nonprofit legal service corporation, a health maintenance organization as defined in chapter 41 of this title or as defined in chapter 62 of title 42, or any other entity providing a plan of health benefits subject to state insurance regulation; and (iii) an organization that for consideration assumes certain risks for an insured. Insurer organizations may include corporations, stock companies, mutual companies, risk retention groups, reciprocals, captives, Lloyds associations, and government residual plans.

(9) "License" means a document issued by this state's insurance commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier;

(10) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (gap) insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the insurance commissioner determines should be designated a form of limited line credit insurance;

(11) "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy;

(12) "Limited lines insurance" means those lines of insurance that the insurance commissioner deems necessary to recognize for purposes of complying with subsection 27-2.4-10(e);

(13) "Limited lines producer" means a person authorized by the insurance commissioner to sell, solicit or negotiate limited lines insurance;

(14) "NAIC" means National Association of Insurance Commissioners;

(15) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that

act either sells insurance or obtains insurance from insurers for purchasers;

(16) "Person" means an individual;

(17) "Resident" means a person who either resides in Rhode Island or maintains an office in Rhode Island where the business of producing insurance is transacted and designates Rhode Island as the residence for purposes of licensure;

(18) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company;

(19) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company;

(20) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of an insurance producer's authority to transact insurance;

(21) "Uniform application" means the current version of the NAIC uniform application for resident and nonresident insurance producer licensing.

27-2.4-16. Notification to insurance commissioner of termination.

(a) **Termination for cause.** An insurer or authorized representative of the insurer that terminates the appointment, employment contract or other insurance business relationship with an insurance producer shall notify the insurance commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the insurance commissioner, if the reason for termination is one of the reasons set forth in § 27-2.4-14 or the insurer has knowledge the insurance producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in § 27-2.4-14. Upon the written request of the insurance commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the insurance producer.

(b) **Termination without cause.** An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason not set forth in § 27-2.4-14, shall notify the insurance commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the insurance commissioner. Upon written request of the insurance commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

~~(b)~~(c) **Ongoing notification requirement.** The insurer or the authorized representative of the insurer shall promptly notify the insurance commissioner in a format acceptable to the insurance commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the insurance commissioner in accordance with subsection (a) of this section had the insurer then known of its existence.

~~(c)~~(d) **Copy of notification to be provided to the insurance producer.**

(1) Within fifteen (15) days after making the notification required by subsections (a) and ~~(b)~~(c) of this section, the insurer shall mail a copy of the notification to the insurance producer at his or her last known address. If the insurance producer is terminated for cause for any of the reasons listed in § 27-2.4-14, the insurer shall provide a copy of the notification to the insurance producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within thirty (30) days after the insurance producer has received the original or additional notification, the insurance producer may file written comments concerning the substance of the notification with the insurance commissioner. The insurance producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the insurance commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the insurance producer as permitted under subsection ~~(e)~~(f) of this section.

~~(d)~~(e) **Immunities.**

(1) In the absence of actual malice, an insurer, the authorized representative of the insurer, an insurance producer, the insurance commissioner, or an organization of which the insurance commissioner is a member and that compiles the information and makes it available to other insurance commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, except as provided in this section, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, except as provided in this section, as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the insurance commissioner, from an insurer or insurance producer; or a statement by a terminating insurer or insurance producer to an insurer or insurance producer limited solely and exclusively to whether a termination for cause under subsection (a) of this section was reported to the insurance commissioner, provided that the propriety of any termination for cause under subsection (a) of this section is certified in writing by an officer or authorized representative of the insurer or insurance producer terminating the relationship.

(2) In any action brought against a person that may have immunity under this chapter for making any statement required by this section or providing any information relating to any statement that may be requested by the insurance commissioner, the party bringing the action shall plead specifically in any allegation that subdivision ~~(d)~~(e)(1) of this section does not apply because the person making the statement or providing the information did so with actual malice.

(3) This chapter shall not abrogate or modify any existing statutory or common law privileges or immunities.

~~(e)~~(f) **Confidentiality.**

(1) Any documents, materials or other information in the control or possession of the department that is furnished by an insurer, insurance producer or an employee or agent of the insurer or insurance producer acting on behalf of the insurer or insurance producer, or obtained by the insurance commissioner in an investigation pursuant to this section, shall be confidential by law and privileged, shall not be subject to chapter 2 of title 38, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The insurance commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the insurance commissioner's duties.

(2) Neither the insurance commissioner nor any person who received documents, materials or other information while acting under the authority of the insurance commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to this chapter.

(3) In order to assist in the performance of the insurance commissioner's duties under this chapter, the insurance commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to this chapter, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(ii) May receive documents, materials or information, including confidential and privileged documents, materials or information, from the NAIC, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information;

(iii) May enter into agreements governing sharing and use of information consistent with this subsection;

(iv) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in this chapter;

(v) Nothing in this chapter shall prohibit the insurance commissioner from releasing final,

adjudicated actions including for cause terminations that are open to public inspection pursuant to chapter 2 of title 38 to a database or other clearinghouse service maintained by the NAIC, its affiliates or subsidiaries; and

(vi) If the department releases to an unauthorized third party any documents, materials or other information provided to the department pursuant to this section, then the department shall be subject to a fine not to exceed one thousand dollars ($1,000) after a hearing on this violation brought in the Superior Court.

~~(f)~~(g) **Penalties for failing to report.** An insurer, the authorized representative of the insurer, or insurance producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with § 42-14-16.

SECTION 2. Section 27-10-1.1 of the General Laws in Chapter 27-10 entitled "Claim Adjusters" is hereby amended to read as follows:

27-10-1.1. Definitions.

(a) "Adjuster" means an individual licensed as either a public company or independent adjuster.

(b) "Catastrophic disaster" according to the Federal Response Plan, means an event that results in large numbers of deaths and injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; and severely affects state, local, and private sector capabilities to begin and sustain response activities. A catastrophic disaster shall be declared by the President of the United States, the governor of the state, or the insurance commissioner.

(c) "Company adjuster" means a person who:

(1) Is an individual who contracts for compensation with insurers or self-insurers as an employee; and

(2) Investigates, negotiates, or settles property, casualty, or workers' compensation claims for insurers or for self-insurers as an employee.

(d) "Department" means the insurance division of the department of business regulation.

(e) "Home state" means the District of Columbia and any state or territory of the United States in which the adjuster's principal place of residence or principal place of business is located. If neither the state in which the ~~public~~ independent or company adjuster maintains the principal place of residence, nor the state in which the adjuster maintains the principal place of business, has

a substantially similar law governing adjusters, the adjuster may declare another state in which it becomes licensed and acts as ~~a public~~ an independent or company adjuster to be the "home state." Designated home state is not available for public adjusters.

(f) "Independent adjuster" means a person who:

(1) Is an individual who contracts for compensation with insurers or self-insurers as an independent contractor; or

(2) Investigates, negotiates, or settles property, casualty, or workers' compensation claims for insurers or for self-insurers as an independent contractor.

(g) "Insurance commissioner" means the director of the department of business regulation or his or her designee.

(h) "NAIC" means the National Association of Insurance Commissioners.

(i) "Public adjuster" means any person who, for compensation or any other thing of value on behalf of the insured:

(1) Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, other than automobile, on behalf of an insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(2) Advertises for employment as a public adjuster of insurance claims or solicits business or represents ~~himself~~ themself or herself to the public as a public adjuster of first-party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(3) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.

(j) "Uniform individual application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Individual Application for resident and nonresident individuals.

SECTION 3. Section 27-13.1-7 of the General Laws in Chapter 27-13.1 entitled "Examinations" is hereby amended to read as follows:

27-13.1-7. Cost of examinations.

(a) The total cost of the examinations shall be borne by the examined companies and shall include the following expenses:

(1) One hundred fifty percent (150%) of the total salaries and benefits paid to the examining

personnel of the banking and insurance division engaged in those examinations less any salary reimbursements;

(2) All reasonable technology costs related to the examination process. Technology costs shall include the actual cost of software and hardware utilized in the examination process and the cost of training ~~examination~~ insurance personnel in the proper use of the software or hardware;

(3) All necessary and reasonable education and training costs incurred by the state to maintain the proficiency and competence of the ~~examining~~ insurance personnel. All these costs shall be incurred in accordance with appropriate state of Rhode Island regulations, guidelines and procedures.

(b) Expenses incurred pursuant to subsections (a)(2) and (a)(3) of this section shall be allocated equally to each company domiciled in Rhode Island no more frequently than annually and shall not exceed an annual average assessment of ~~three thousand five hundred dollars ($3,500)~~ five thousand dollars ($5,000) per company for any given three (3) calendar year period. All revenues collected pursuant to this section shall be deposited as general revenues. That assessment shall be in addition to any taxes and fees payable to the state.

SECTION 4. Sections 27-34.3-2, 27-34.3-3, 27-34.3-5, 27-34.3-6, 27-34.3-7, 27-34.3-8, 27-34.3-9, 27-34.3-11, 27-34.3-12, 27-34.3-13, 27-34.3-14, 27-34.3-19 and 27-34.3-20 of the General Laws in Chapter 27-34.3 entitled "Rhode Island Life and Health Insurance Guaranty Association Act" are hereby amended to read as follows:

27-34.3-2. Purpose.

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

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

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

27-34.3-3. Coverage and limitations.

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

(b) of this section:

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

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

(i) Are residents; or

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

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

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

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

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

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

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

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

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

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

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

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

The state in which the contract owner resides has an association similar to the association

created by this chapter; and

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

(5) This chapter shall not provide coverage to:

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

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

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

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

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

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

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

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

pursuant to the reinsurance policy or contract;

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

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

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

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

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

(B) A minimum premium group insurance plan;

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

(D) An administrative services only contract;

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

(A) Dividends or experience rating credits;

(B) Voting rights; or

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

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

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

(viii) A portion of unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

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

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

(A) Claims based on marketing materials;

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

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

(D) Extracontractual claims; or

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

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

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

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

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

pursuant thereto.; or

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

(3) The exclusion from coverage referenced in subsection (b)(2)(iii) of this section 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) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

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

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

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

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

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

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

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

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

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

(iii) With respect to each payee of a structured settlement annuity or beneficiary or beneficiaries, of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present

value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values if any;

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

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

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

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

(d) In performing its obligations to provide coverage under § 27-34.3-8, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed,

assumed, reinsured, reissued or performed, contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

27-34.3-5. Definitions.

As used in this chapter:

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

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

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

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

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

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

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

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

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

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

(i) Accident only insurance;

(ii) Credit insurance;

(iii) Dental only insurance;

(iv) Vision only insurance;

(v) Medicare Supplement insurance;

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

(vii) Disability income insurance;

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

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

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

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

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

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

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

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

(iii) A fraternal benefit society; or

(iv) A mandatory state pooling plan; or

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

(vi) An insurance exchange; or

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

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

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

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

recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder and policy owner do not include persons with a mere beneficial interest in a policy or contract.

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

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

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

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

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

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

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

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

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

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

is located;

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

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

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

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

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

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

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

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

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

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

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

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

27-34.3-6. Creation of the association.

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

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

(i) Life insurance account;

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

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

(2) The health insurance account.

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

27-34.3-7. Board of directors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) With respect to ~~life and health insurance policies and annuities~~ policies and contracts, assure payment of benefits ~~for premiums identical to the premiums and benefits (except for terms of conversion and renewability)~~ that would have been payable under the policies or contracts of the

insolvent insurer, for claims incurred:

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

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

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

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

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

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

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

(v)(A) Alternative policies or contracts adopted by the association shall be subject to the approval of the ~~domiciliary insurance~~ commissioner ~~and the receivership court~~. The association

may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

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

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

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

(viii) When proceeding under paragraph (b)(2) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with § 27-34.3-3(b)(2)(iii).

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

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

(e) The protection provided by this chapter shall not apply where any guaranty protection

is provided to residents of this state by laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

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

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

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

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

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

powers and duties of the association under this chapter with respect to the insolvent insurers.

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

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

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

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

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

respect of a qualified assignment under § 130 of the United States Internal Revenue Code, 26 U.S.C. § 130.

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

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

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

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

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

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

(4) Employ or retain persons as are necessary or appropriate to handle the financial transactions of the association, and to perform any other functions as become necessary or proper under this chapter;

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

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

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

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

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

it provides coverage under this chapter; and

~~(9)~~(10) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(m) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

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

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

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

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

(ii) The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies or annuities covered in whole or in part, by the association

provided, that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(A) The amount received by the association; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

shall apply to reinsurance agreements covering property or casualty risks.

(o) The board of directors of the association shall have discretion and shall exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

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

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

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

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

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

(i) A fixed interest rate; or

(ii) Payment of dividends with minimum guarantees; or

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

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

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

27-34.3-9. Assessments.

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

nine percent (9%) per annum on and after the due date.

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

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

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

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

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

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

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

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

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

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

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

(iii) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon after this as permitted by this chapter.

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

(3) If the maximum assessment for a subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision (c)(2) of this section, the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (1) of this subsection.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each 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 claims.

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

(h) The association shall issue to each member insurer paying an assessment under this chapter, other than Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the 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 that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the

commissioner.

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

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member ~~company~~ 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.

27-34.3-11. Duties and powers of the commissioner.

In addition to the duties and powers enumerated in this chapter,

(a) The commissioner shall:

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

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

(3) [Deleted by P.L. 2009, ch. 158, § 1 and by P.L. 2009, ch. 169, § 1].

(4) Maintain the confidentiality and privileged status of confidential association information provided to the commissioner or department of business regulation.

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

(c) A final action of the board of directors or the association may be appealed to the commissioner by any member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the commissioner shall be subject to judicial review.

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

(e) The commissioner shall not participate in the association's adjudication of a protest by an insurer pursuant to § 27-34.3-9(i).

27-34.3-12. Prevention of insolvencies.

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

(a) It shall be the duty of the commissioner:

(1) To notify the commissioners of all the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the commissioner takes any of the following actions against a member insurer:

(i) Revocation of license;

(ii) Suspension of license; or

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

(2) To report to the board of directors when the commissioner has taken any of the actions set forth in paragraph (1) of this subdivision or has received a report from any other commissioner indicating that this action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) To report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member ~~company~~ insurer that the ~~company~~ insurer may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the NAIC insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners, and the board may use the information contained in the ratios and listings in carrying out its duties and responsibilities under this section. The report and the information contained in it shall be kept confidential by the board of directors until the time it is made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and ~~companies~~ insurers or health maintenance organizations seeking admission to transact insurance business in this state.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any ~~company~~ insurer or health

maintenance organization seeking to do ~~an insurance~~ business in this state. The reports and recommendations shall not be considered public documents.

(d) The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

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

27-34.3-13. Credits for assessments paid (tax offsets).

(a) A member insurer may offset against its premium, franchise or income tax liability (or liabilities) to this state an assessment described in § 27-34.3-9(h) to the extent of ten percent (10%) of the amount of the assessment for each of the five (5) calendar years following the year in which the assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium, franchise, or income tax liability (or liabilities) for the year it ceases doing business.

(b) Any sums which are acquired by refund, pursuant to § 27-34.3-9(f), from the association by member insurers, and which have been offset against premium, franchise or income taxes as provided in subsection (a) of this section, shall be paid by the member insurers to this state in any manner that the tax authorities may require. The association shall notify the commissioner that refunds have been made.

27-34.3-14. Miscellaneous provisions.

(a) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under § 27-34.3-8. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under § 27-34.3-15.

(c) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to § 27-34.3-8(k). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies or

contracts, as used in this subsection, are that proportion of the assets which the reserves that should have been established for covered policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in subsection (c) of this section and consistent with § 27-14.3-38, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshalled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of ~~an~~ a member insurer by the receivership court, made an application to the court for the approval of a proposal to disperse assets out of marshalled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(e)(1) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees and 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 the insolvent insurer. In that determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders, 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 on the claims for funds expended in carrying out its powers and duties under § 27-34.3-8 with respect to the member insurer have been fully recovered by the association.

(f)(1) If an order for liquidation or rehabilitation of ~~an~~ a member insurer domiciled in this state has been entered, the receiver appointed under the 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 subdivisions (2) — (4) of this subsection.

(2) No 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 received. Any person who was an affiliate who controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two (2) 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 subdivision (3) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

27-34.3-19. Prohibited advertisement of insurance guaranty association act in insurance sales — Notice to policy owners.

(a) No person, including ~~an~~ a member insurer, agent, producer, or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or in the form of e-mail or an electronic website, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by the Rhode Island life and health insurance guaranty association act; provided, that this section shall not apply to the association or any other entity which does not sell or solicit insurance or other coverage by a health maintenance organization. The use of the protection afforded by this chapter, other than as provided by this section, by any person in the sale, marketing or advertising of insurance constitutes unfair methods of competition and unfair or deceptive acts or practices under chapter 29 of this title and is subject to the sanctions imposed in that chapter.

(b) The association shall prepare a summary document describing the general purposes and current limitations of this chapter in compliance with subsection (c) of this section. This document shall be submitted to the commissioner for approval. At the expiration of the sixty (60) days after the date on which the commissioner approves the document, ~~an~~ a member insurer may not deliver a policy or contract to a policy owner, ~~or~~ contract owner, certificate holder or enrollee unless the summary document is delivered to the policy owner, ~~or~~ contract owner, certificate holder or

enrollee at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the policy owner, contract owner, certificate holder or enrollee contract or the ~~owner of the policy or contract~~ policy owner, contract owner, certificate holder or enrollee is covered in the event of the impairment or insolvency of a member insurer. The summary document shall be revised by the association as amendments to this chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee or insured any greater rights than those stated in this act.

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

(1) State the name and address of the association and the insurance department;

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

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

(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 health maintenance organization coverage;

(5) State that the ~~policy or contract owner~~ policy owner, contract owner, certificate holder or enrollee should not rely on coverage under the association when selecting an insurer or health maintenance organization;

(6) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and

(7) Provide other information as directed by the commissioner including, but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under chapter 2 of title 38.

(d) A member insurer shall retain evidence of compliance with subsection (b) for so long as the policy or contract for which the notice is given remains in effect.

27-34.3-20. Prospective application.

This chapter shall not apply to any member insurer that is insolvent or unable to fulfill its contractual obligations prior to January 1, 1996, and any such insurer shall be subject to the provisions under chapter 34.1 of this title. Nothing in this chapter shall be construed to require an

insurer to recompute its assessment bases for any year prior to January 1, 2005, and any assessment bases computed between January 1, 1966 and December 31, 2004 are hereby acknowledged and recognized as factual on the basis of premium date collected from or reported by member insurers with respect to those years.

SECTION 5. Section 42-14-5 of the General Laws in Chapter 42-14 entitled "Department of Business Regulation" is hereby amended to read as follows:

42-14-5. Superintendents of banking and insurance.

(a) The superintendents of banking and insurance shall administer the functions of the department relating to the regulation and control of banking and insurance.

(b) Wherever the words "banking administrator" or "banking commissioner" or "insurance administrator" or "insurance commissioner" occur in this chapter or any general law, public law, act, or resolution of the general assembly or department regulation, they shall be construed to mean superintendent of banking and superintendent of insurance except as delineated in subsection (d) below.

(c) "Health insurance" shall mean "health insurance coverage," as defined in §§ 27-18.5-2 and 27-18.6-2, "health benefit plan," as defined in § 27-50-3 and a "medical supplement policy," as defined in § 27-18.2-1 or coverage similar to a Medicare supplement policy that is issued to an employer to cover retirees, and dental coverage, including, but not limited to, coverage provided by a nonprofit dental service plan as defined in § 27-20.1-1(3).

(d) Whenever the words "commissioner," "insurance commissioner," "health insurance commissioner" or "director" appear in Title 27 or Title 42, those words shall be construed to mean the health insurance commissioner established pursuant to § 42-14.5-1 with respect to all matters relating to health insurance. The health insurance commissioner shall have sole and exclusive jurisdiction over enforcement of those statutes with respect to all matters relating to health insurance except for purposes of producer licensing or producer appointments.

(e) Whenever the word "director" appears or is a defined term in title 19, this word shall be construed to mean the superintendent of banking established pursuant to this section.

(f) Whenever the word "director" or "commissioner" appears or is a defined term in title 27, this word shall be construed to mean the superintendent of insurance established pursuant to this section except as delineated in subsection (d) of this section.

SECTION 6. Chapter 27-2.4 of the General Laws entitled "Producer Licensing Act" is hereby amended by adding thereto the following section:

27-2.4-14.1. Appointments.

(a) An insurance producer shall not act as an agent of an insurer unless the insurance

producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(b) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the insurance commissioner, a notice of appointment within fifteen (15) days from the date the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

(c) An insurer shall pay an appointment fee, in the amount and method of payment set forth in a regulation promulgated for that purpose, for each insurance producer appointed by the insurer.

(d) An insurer shall remit, in a manner prescribed by the insurance commissioner, a renewal appointment fee in the amount set forth in a regulation promulgated for that purpose.

SECTION 7. Chapter 27-9 of the General Laws entitled "Casualty Insurance Rating" is hereby amended by adding thereto the following section:

27-9-57. Unfair discrimination.

(a) No individual or entity subject to this chapter shall, because of race, color, creed, national origin, or disability:

(1) Make any distinction or discrimination between persons as to the premiums or rates charged for insurance policies.

(2) Demand or require a greater premium from any persons than it requires at that time from others in similar cases.

(3) Insert in the policy any condition, or make any stipulation, whereby the insured binds themselves, or their heirs, executors, administrators, or assigns, to accept any sum or service less than the full value or amount of such policy in case of a claim thereon except such conditions and stipulations as are imposed upon others in similar cases; and any such stipulation or condition so made or inserted shall be void.

SECTION 8. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 1.3

INSURANCE DATA SECURITY ACT

27-1.3-1. Title.

This chapter shall be known and may be cited as the "Insurance Data Security Act."

27-1.3-2. Purpose and intent.

(a) The purpose and intent of this chapter is to establish standards for data security and standards for the investigation of, and notification to the commissioner of, a cybersecurity event

applicable to licensees, as defined in § 27-1.3-3. Notwithstanding any other provision of law, this chapter establishes the exclusive state standards applicable to licensees for data security, the investigation of a cybersecurity event as defined in § 27-1.3-3, and notification to the commissioner. These provisions do not affect a licensee's responsibility to notify consumers in accordance with § 27-1.3-6(c).

(b) This chapter may not be construed to create or imply a private cause of action for violation of its provisions nor may it be construed to curtail a private cause of action which would otherwise exist in the absence of this chapter.

27-1.3-3. Definitions.

As used in this chapter, the following terms shall have the following meanings:

(1) "Authorized individual" means an individual known to and screened by the licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and its information systems.

(2) "Commissioner" shall have the meaning established in § 42-14-5.

(3) "Consumer" means an individual, including, but not limited to, applicants, policyholders, insureds, beneficiaries, claimants, and certificate holders who is a resident of this state and whose nonpublic information is in a licensee's possession, custody or control.

(4) "Cybersecurity event" means an event resulting in unauthorized access to, disruption or misuse of, an information system or nonpublic information stored on such information system.

(i) The term "cybersecurity event" does not include the unauthorized acquisition of encrypted nonpublic information if the encryption, process or key is not also acquired, released or used without authorization.

(ii) The term "cybersecurity event" does not include an event with regard to which the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

(5) "Department" means the department of business regulation, division of insurance.

(6) "Encrypted" means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key.

(7) "Information security program" means the administrative, technical, and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information.

(8) "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic information, as well as any specialized system such as industrial/process controls

systems, telephone switching and private branch exchange systems, and environmental control systems.

(9) "Licensee" means any person licensed, authorized to operate, or registered, or required to be licensed, authorized, or registered pursuant to the insurance laws of this state, but shall not include a purchasing group or a risk retention group chartered and licensed in a state other than this state or a licensee that is acting as an assuming insurer that is domiciled in another state or jurisdiction.

(10) "Multi-factor authentication" means authentication through verification of at least two (2) of the following types of authentication factors:

(i) Knowledge factors, such as a password; or

(ii) Possession factors, such as a token or text message on a mobile phone; or

(iii) Inherence factors, such as a biometric characteristic.

(11) "Nonpublic information" means information that is not publicly available information and is:

(i) Business related information of a licensee the tampering with which, or unauthorized disclosure, access or use of which, would cause a material adverse impact to the business, operations or security of the licensee;

(ii) Any information concerning a consumer which because of name, number, personal mark, or other identifier can be used to identify such consumer, in combination with any one or more of the following data elements:

(A) Social security number;

(B) Driver's license number or non-driver identification card number;

(C) Account number, credit or debit card number;

(D) Any security code, access code or password that would permit access to a consumer's financial account; or

(E) Biometric records;

(iii) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer and that relates to:

(A) The past, present or future physical, mental, behavioral health or medical condition of any consumer or a member of the consumer's family;

(B) The provision of health care to any consumer; or

(C) Payment for the provision of health care to any consumer.

(12) "Person" means any individual or any non-governmental entity, including, but not limited to, any non-governmental partnership, corporation, limited liability company, branch,

agency or association.

(13) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from: federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law:

(i) For the purposes of this definition, a licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(A) That the information is of the type that is available to the general public; and

(B) Whether a consumer can direct that the information not be made available to the general public and the consumer has not done so.

(14) "Risk assessment" means the procedure that each licensee is required to complete under § 27-1.3-4(c).

(15) "State" means the State of Rhode Island.

(16) "Third-party service provider" means a person, not otherwise defined as a licensee, that contracts with a licensee to maintain, process, store or otherwise is permitted access to nonpublic information through its provision of services to the licensee.

27-1.3-4. Information security program.

(a) Implementation of an information security program. Commensurate with the size and complexity of a licensee, the nature and scope of a licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody or control, shall develop, implement, and maintain a comprehensive written information security program, based on the licensee's risk assessment and that contains administrative, technical, and physical safeguards for the protection of nonpublic information and the licensee's information system.

(b) Objectives of information security program. A licensee's information security program shall be designed to:

(1) Protect the security and confidentiality of nonpublic information and the security of the information system;

(2) Protect against any threats or hazards to the security or integrity of nonpublic information and the information system;

(3) Protect against unauthorized access to or use of nonpublic information, and minimize the likelihood of harm to any consumer; and

(4) Define and periodically reevaluate a schedule for retention of nonpublic information

and a mechanism for its destruction when no longer needed.

(c) Risk assessment. The licensee shall:

(1) Designate one or more employees, an affiliate, or an outside vendor designated to act on behalf of the licensee who is responsible for the information security program;

(2) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration or destruction of nonpublic information, including the security of information systems and nonpublic information that are accessible to, or held by, third-party service providers;

(3) Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of the nonpublic information;

(4) Assess the sufficiency of policies, procedures, information systems and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the licensee's operations, including:

(i) Employee training and management;

(ii) Information systems, including network and software design, as well as information classification, governance, processing, storage, transmission, and disposal; and

(iii) Detecting, preventing, and responding to attacks, intrusions, or other systems failures; and

(5) Implement information safeguards to manage the threats identified in its ongoing assessment, and no less than annually, assess the effectiveness of the safeguards' key controls, systems, and procedures.

(d) Risk management. Based on its risk assessment, the licensee shall:

(1) Design its information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody or control;

(2) Determine which security measures listed below are appropriate and implement such security measures:

(i) Place access controls on information systems, including controls to authenticate and permit access only to authorized individuals to protect against the unauthorized acquisition of nonpublic information;

(ii) Identify and manage the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization's risk strategy;

(iii) Restrict access at physical locations containing nonpublic information only to authorized individuals;

(iv) Protect, by encryption or other appropriate means, all nonpublic information while being transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media;

(v) Adopt secure development practices for in-house developed applications utilized by the licensee and procedures for evaluating, assessing or testing the security of externally developed applications utilized by the licensee;

(vi) Modify the information system in accordance with the licensee's information security program;

(vii) Utilize effective controls, which may include multi-factor authentication procedures for any individual accessing nonpublic information;

(viii) Regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems;

(ix) Include audit trails within the information security program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee;

(x) Implement measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures; and

(xi) Develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format;

(3) Include cybersecurity risks in the licensee's enterprise risk management process;

(4) Stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared; and

(5) Provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment.

(e) Oversight by board of directors. If the licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum:

(1) Require the licensee's executive management, or designees, to develop, implement, and maintain the licensee's information security program;

(2) Require the licensee's executive management, or designees, to report in writing at least annually, the following information:

(i) The overall status of the information security program and the licensee's compliance with this chapter; and

(ii) Material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, cybersecurity events or violations and management's responses thereto, or recommendations for changes in the information security program; and

(3) If executive management delegates any of its responsibilities pursuant to this section, it shall oversee the development, implementation and maintenance of the licensee's information security program prepared by the designee(s) and shall receive a report from the designee(s) complying with the requirements of the report to the board of directors.

(f) Oversight of third-party service provider arrangements.

(1) A licensee shall exercise due diligence in selecting its third-party service provider; and

(2) A licensee shall take reasonable steps to request a third-party service provider to implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information that are accessible to, or held by, the third-party service provider.

(g) Program adjustments. The licensee shall monitor, evaluate and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to information systems.

(h) Incident response plan:

(1) As part of its information security program, each licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity or availability of nonpublic information in its possession, the licensee's information systems, or the continuing functionality of any aspect of the licensee's business or operations;

(2) Such incident response plan shall address the following areas:

(i) The internal process for responding to a cybersecurity event;

(ii) The goals of the incident response plan;

(iii) The definition of clear roles, responsibilities and levels of decision-making authority;

(iv) External and internal communications and information sharing;

(v) Identification of requirements for the remediation of any identified weaknesses in information systems and associated controls;

(vi) Documentation and reporting regarding cybersecurity events and related incident response activities; and

(vii) The evaluation and revision as necessary of the incident response plan following a cybersecurity event.

(i) Annual certification to commissioner of domiciliary state. Annually, each insurer domiciled in this state shall submit to the commissioner a written statement by April 15 certifying that the insurer is in compliance with the requirements set forth in this section. Each insurer shall maintain for examination by the department all records, schedules and data supporting this certificate for a period of five (5) years. To the extent an insurer has identified areas, systems or processes that require material improvement, updating or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address such areas, systems or processes. This documentation must be available for inspection by the commissioner.

27-1.3-5. Investigation of a cybersecurity event.

(a) If the licensee learns that a cybersecurity event has or may have occurred, the licensee, or an outside vendor and/or service provider designated to act on behalf of the licensee, shall conduct a prompt investigation.

(b) During the investigation, the licensee, or an outside vendor and/or service provider designated to act on behalf of the licensee, shall, at a minimum, determine as much of the following information as possible:

(1) Whether a cybersecurity event has occurred;

(2) Assess the nature and scope of the cybersecurity event;

(3) Identify any nonpublic information that may have been involved in the cybersecurity event; and

(4) Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release or use of nonpublic information in the licensee's possession, custody or control.

(c) If the licensee learns that a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, and it has or may have impacted the licensee's nonpublic information, the licensee shall make reasonable efforts to complete the steps set forth in subsection (b) of this section or make reasonable efforts to confirm and document that the third-party service provider has completed those steps.

(d) The licensee shall maintain records concerning all cybersecurity events for a period of at least five (5) years from the date of the cybersecurity event and shall produce those records upon demand of the commissioner.

27-1.3-6. Notification of a cybersecurity event.

(a) Notification to the commissioner. Each licensee shall notify the commissioner as promptly as possible but in no event later than three (3) business days from a determination that a cybersecurity event has occurred when either of the following criteria has been met:

(1) This state is the licensee's state of domicile, in the case of an insurer, or this state is the licensee's home state, in the case of a producer, as those terms are defined in § 27-2.4-2; or

(2) The licensee reasonably believes that the nonpublic information involved affects two hundred fifty (250) or more consumers residing in this state and that either of the following apply:

(i) A cybersecurity event impacting the licensee of which notice is required to be provided to any government body, self-regulatory agency or any other supervisory body pursuant to any state or federal law; or

(ii) A cybersecurity event that has a reasonable likelihood of materially harming:

(A) Any consumer residing in this state; or

(B) Any material part of the normal operation(s) of the licensee.

(b) The licensee shall provide any information required by this section in electronic form as directed by the commissioner. The licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the commissioner concerning the cybersecurity event. The licensee shall provide as much of the following information as possible:

(1) Date of the cybersecurity event;

(2) Description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of third-party service providers, if any;

(3) How the cybersecurity event was discovered;

(4) Whether any lost, stolen, or breached information has been recovered and if so, how this recovery was achieved;

(5) The identity of the source of the cybersecurity event;

(6) Whether the licensee has filed a police report or has notified any regulatory, government or law enforcement agencies and, if so, when such notification was provided;

(7) Description of the specific types of information acquired without authorization. Specific types of information consisting of particular data elements including, for example, types of medical information, types of financial information or types of information allowing identification of the consumer;

(8) The period during which the information system was compromised by the cybersecurity event;

(9) The number of total consumers in this state affected by the cybersecurity event. The

licensee shall provide the best estimate in the initial report to the commissioner and update this estimate with each subsequent report to the commissioner pursuant to this section;

(10) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

(11) Description of efforts being undertaken to remediate the situation which permitted the cybersecurity event to occur;

(12) A copy of the licensee's privacy policy and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the cybersecurity event; and

(13) Name of a contact person who is both familiar with the cybersecurity event and authorized to act for the licensee.

(c) Notification to consumers. A licensee shall comply with chapter 49.3 of title 11, as applicable, and provide a copy of the notice sent to consumers under that chapter to the commissioner, when a licensee is required to notify the commissioner under subsection (a) of this section.

(d) Notice regarding cybersecurity events of third-party service providers:

(1) In the case of a cybersecurity event involving a licensee's nonpublic information in a system maintained by a third-party service provider, of which the licensee has become aware, the licensee shall treat that event as it would under subsection (a) of this section;

(2) The computation of the licensee's deadlines shall begin on the day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner;

(3) Nothing in this chapter shall prevent or abrogate an agreement between a licensee and another licensee, a third-party service provider or any other party to fulfill any of the investigation requirements imposed under § 27-1.3-5 or notice requirements imposed under this section.

(e) Notice regarding cybersecurity events of reinsurers to insurers:

(1)(i) In the case of a cybersecurity event involving nonpublic information that is used by the licensee that is acting as an assuming insurer or in the possession, custody or control of a licensee that is acting as an assuming insurer and that does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within seventy-two (72) hours of making the determination that a cybersecurity event has occurred;

(ii) The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under chapter 49.3 of title 11 ("identity theft protection act of 2015"), and any other notification requirements relating to a cybersecurity

event imposed under this section;

(2)(i) In the case of a cybersecurity event involving nonpublic information that is in the possession, custody or control of a third-party service provider of a licensee that is an assuming insurer, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within seventy-two (72) hours of receiving notice from its third-party service provider that a cybersecurity event has occurred;

(ii) The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under chapter 49.3 of title 11 and any other notification requirements relating to a cybersecurity event imposed under this section.

(f) Notice regarding cybersecurity events of insurers to producers of record.

(1) In the case of a cybersecurity event involving nonpublic information that is in the possession, custody or control of a licensee that is an insurer or its third-party service provider and for which a consumer accessed the insurer's services through an independent insurance producer, the insurer shall notify the producers of record of all affected consumers as soon as practicable as directed by the commissioner.

(2) The insurer is excused from this obligation for those instances in which it does not have the current producer of record information for any individual consumer.

27-1.3-7. Power of commissioner.

(a) The commissioner shall have power to examine and investigate into the affairs of a licensee to determine whether the licensee has been or is engaged in any conduct in violation of this chapter. This power is in addition to the powers which the commissioner has pursuant to chapter 13.1 of title 27 and any such investigation or examination shall be conducted pursuant to chapter 13.1 of title 27.

(b) Whenever the commissioner has reason to believe that a licensee has been or is engaged in conduct in this state which violates this chapter, the commissioner may take action that is necessary or appropriate to enforce the provisions of this chapter.

27-1.3-8. Confidentiality.

(a) Any documents, materials or other information in the control or possession of the department that are furnished by a licensee or an employee or agent thereof acting on behalf of a licensee pursuant to §§ 27-1.3-4(i) and 27-1.3-6(b)(2), (b)(3), (b)(4), (b)(5), (b)(8), (b)(10), and (b)(11), or that are obtained by the commissioner in an investigation or examination pursuant to § 27-1.3-7 shall be confidential by law and privileged, shall not be subject to chapter 2 of title 38, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, the commissioner is authorized to use the documents,

materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

(b) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the commissioner's duties under this chapter, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities; provided that, the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information;

(3) May share documents, materials or other information subject to subsection (a) of this section, with a third-party consultant or vendor provided the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material or other information; and

(4) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (c) of this section.

(e) Nothing in this chapter shall prohibit the commissioner from releasing final, adjudicated actions that are open to public inspection pursuant to chapter 2 of title 38 to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

27-1.3-9. Exceptions.

(a) The following exceptions shall apply to this chapter:

(1) A licensee meeting one of the following criteria is exempt from § 27-1.3-4:

(1) A licensee with fewer than twenty-five (25) employees, including any independent contractors with access to the licensee's nonpublic information; or

(2) A licensee with less than five million dollars ($5,000,000) in gross annual revenue; or

(3) A licensee with less than ten million dollars ($10,000,000) in assets, measured at the end of the licensee's fiscal year.

(4) A licensee subject to and in compliance with Pub. L. 104-191, 110 Stat. 1936, enacted August 21, 1996 (Health Insurance Portability and Accountability Act) and related privacy, security and breach notification regulations pursuant to Code of Federal Regulations, Parts 160 and 164, and Pub. L. 111-5, 123 Stat. 226, enacted February 17, 2009 (Health Information Technology) is considered to meet the requirements of this chapter, other than the requirements of §§ 27-1.3-6(a) and (b) regarding notification to the commissioner, if:

(i) The licensee maintains a program for information security and breach notification that treats all nonpublic information relating to consumers in this state in the same manner as protected health information;

(ii) The licensee annually submits to the commissioner a written statement certifying that the licensee is in compliance with the requirements of this subsection; and

(iii) The commissioner has not issued a determination finding that the applicable federal regulations are materially less stringent than the requirements of this chapter.

(5) An employee, agent, representative or designee of a licensee, who is also a licensee, is exempt from § 27-1.3-4 and need not develop its own information security program to the extent that the employee, agent, representative or designee is covered by the information security program of the other licensee.

(b) In the event that a licensee ceases to qualify for an exception, the licensee shall have one hundred eighty (180) days to comply with this chapter.

27-1.3-10. Penalties.

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

27-1.3-11. Severability.

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision

to other persons or circumstances shall not be affected thereby.

SECTION 9. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 82

PET INSURANCE ACT

27-82-1. Short Title.

This act shall be known and may be cited as the "Pet Insurance Act."

27-82-2. Scope and Purpose.

(a) The purpose of this act is to promote the public welfare by creating a comprehensive legal framework within which pet insurance may be sold in this state.

(b) The requirements of this act shall apply to pet insurance policies that are issued to any resident of this state and are sold, solicited, negotiated, or offered in this state, and policies or certificates that are delivered or issued for delivery in this state.

(c) All other applicable provisions of this state's insurance laws shall continue to apply to pet insurance except that the specific provisions of this act shall supersede any general provisions of law that would otherwise be applicable to pet insurance.

27-82-3. Definitions.

(a) If a pet insurer uses any of the terms in this chapter in a policy of pet insurance, the pet insurer shall use the definition of each of those terms as set forth herein and include the definition of the term(s) in the policy. The pet insurer shall also make the definition available through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.

(b) Nothing in this chapter shall in any way prohibit or limit the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions defined below.

(c) As used in this chapter:

(1) "Chronic condition" means a condition that can be treated or managed, but not cured.

(2) "Congenital anomaly or disorder" means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

(3) "Hereditary disorder" means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

(4) "Orthopedic" refers to conditions affecting the bones, skeletal muscle, cartilage, tendons, ligaments, and joints. It includes, but is not limited to, elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments. It does

not include cancers or metabolic, hemopoietic, or autoimmune diseases.

(5) "Pet insurance" means a property insurance policy that provides coverage for accidents and illnesses of pets.

(6) "Preexisting condition" means any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

(i) A veterinarian provided medical advice;

(ii) The pet received previous treatment; or

(iii) Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

(iv) A condition for which coverage is afforded on a policy cannot be considered a preexisting condition on any renewal of the policy.

(7) "Renewal" means to issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

(8) "Veterinarian" means an individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.

(9) "Veterinary expenses" means the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by a veterinarian.

(10) "Waiting period" means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

(11) "Wellness program" means a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. If any wellness program:

(i) Pays or indemnifies another as to loss from certain contingencies called "risks," including through reinsurance;

(ii) Pays or grants a specified amount or determinable benefit to another in connection with ascertainable risk contingencies; or

(iii) Acts as a surety, it is transacting in the business of insurance and is subject to the insurance code, as defined in § 27-54.1-1. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two (2) parties as being "the business of insurance," unless other indications of insurance also exist.

27-82-4. Disclosures.

(a) A pet insurer transacting pet insurance shall disclose the following to consumers:

(1) If the policy excludes coverage due to any of the following:

(i) A preexisting condition;

(ii) A hereditary disorder;

(iii) A congenital anomaly or disorder; or

(iv) A chronic condition.

(2) If the policy includes any other exclusions, the following statement: "Other exclusions may apply. Please refer to the exclusions section of the policy for more information."

(3) Any policy provision that limits coverage through a waiting or affiliation period, a deductible, coinsurance, or an annual or lifetime policy limit.

(4) Whether the pet insurer reduces coverage or increases premiums based on the insured's claim history, the age of the covered pet or a change in the geographic location of the insured.

(5) If the underwriting company differs from the brand name used to market and sell the product.

(b) Right to examine and return the policy.

(1) Unless the insured has filed a claim under the pet insurance policy, pet insurance applicants shall have the right to examine and return the policy, certificate or rider to the company or an agent/insurance producer of the company within fifteen (15) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason.

(2) Pet insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. The following free look statement or language substantially similar shall be included:

"You have fifteen (15) days from the day you receive this policy, certificate, or rider to review it, and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office, or you may return it to the agent/insurance producer that you bought it from as long as you have not filed a claim. You must return it within fifteen (15) days of the day you first received it. The company will refund the full amount of any premium paid within thirty (30) days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate, or rider will be void as if it had never been issued."

(c) A pet insurer shall clearly disclose a summary description of the basis or formula on

which the pet insurer determines claim payments under a pet insurance policy within the policy, prior to policy issuance, and through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(d) A pet insurer that uses a benefit schedule to determine claim payment under a pet insurance policy shall do both of the following:

(1) Clearly disclose the applicable benefit schedule in the policy.

(2) Disclose all benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(e) A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall do both of the following:

(1) Include a usual and customary fee limitation provision in the policy that clearly describes the pet insurer's basis for determining usual and customary fees and how that basis is applied in calculating claim payments.

(2) Disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(f) If any medical examination by a licensed veterinarian is required to effectuate coverage, the pet insurer shall clearly and conspicuously disclose the required aspects of the examination prior to purchase and disclose that examination documentation may result in a preexisting condition exclusion.

(g) Waiting periods and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.

(h) The pet insurer shall include a summary of all policy provisions required in subsections (a) through (g) of this section, inclusive, in a separate document titled "insurer disclosure of important policy provisions."

(i) The pet insurer shall post the "insurer disclosure of important policy provisions" document required in subsection (h) of this section through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(j) In connection with the issuance of a new pet insurance policy, the pet insurer shall provide the consumer with a copy of the "insurer disclosure of important policy provisions" document required pursuant to subsection (h) of this section in at least twelve-point (12-point) type when the policy is delivered.

(k) At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall include a written disclosure with the following information, printed in twelve-point (12-point) boldface type:

(1) The address and customer service telephone number of the pet insurer or the agent or broker of record.

(2) If the policy was issued or delivered by an agent or broker, a statement advising the policyholder to contact the broker or agent for assistance.

(l) The disclosures required in this section shall be in addition to any other disclosures required by law or regulation.

27-82-5. Policy Conditions.

(a) A pet insurer may issue policies that exclude coverage on the basis of one or more preexisting conditions with appropriate disclosure to the consumer. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.

(b) A pet insurer may issue policies that impose waiting periods upon effectuation of the policy that do not exceed thirty (30) days for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited. However, an insurer may issue coverage to be effective at 12:01 a.m. on the second calendar day after the purchase, subject only to the following exceptions.

(1) If an insurer elects to conduct individualized underwriting on a specific pet, then coverage must be effective by 12:01 a.m. on the second calendar day after the insurer has determined such pet is eligible for coverage.

(2) An insurer may delay coverage from becoming effective to establish a method for the consumer or group administrator to pay the premium.

(3) For pet insurance coverage acquired by an individual through an employer or organization, the coverage effective date of such pet insurance may be delayed to align with the eligibility and effective date requirements of the employer's or organization's benefit plan.

(4) A pet insurer utilizing a waiting period permitted in subsection (b) of this section shall include a provision in its contract that allows the waiting periods to be waived upon completion of a medical examination. Pet insurers may require the examination to be conducted by a licensed veterinarian after the purchase of the policy.

(i) A medical examination under subsection (b)(1) of this section shall be paid for by the policyholder, unless the policy specifies that the pet insurer will pay for the examination.

(ii) A pet insurer can specify elements to be included as part of the examination and require

documentation thereof; provided, the specifications do not unreasonably restrict a consumer's ability to waive the waiting periods in subsection (b) of this section.

(5) Waiting periods, and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.

(6) If a policy does not include a waiting period for an illness or orthopedic condition, an insurer may set a policy effectuation date that is up to fifteen (15) calendar days after purchase, so long as such policy effectuation date is clearly disclosed and no premium is charged before the policy becomes effective.

(c) A pet insurer must not require a veterinary examination of the covered pet for the insured to have their policy renewed.

(d) If a pet insurer includes any prescriptive, wellness, or non-insurance benefits in the policy form, then it is made part of the policy contract and must follow all applicable laws and regulations in the insurance code.

(e) An insured's eligibility to purchase a pet insurance policy must not be based on participation, or lack of participation, in a separate wellness program.

27-82-6. Sales practices for wellness programs.

(a) A pet insurer and/or producer shall not do the following:

(1) Market a wellness program as pet insurance;

(2) Market a wellness program during the sale, solicitation, or negotiation of pet insurance.

(b) If a wellness program is sold by a pet insurer and/or producer:

(1) The purchase of the wellness program shall not be a requirement to the purchase of pet insurance.

(2) The costs of the wellness program shall be separate and identifiable from any pet insurance policy sold by a pet insurer and/or producer.

(3) The terms and conditions for the wellness program shall be separate from any pet insurance policy sold by a pet insurer and/or producer.

(4) The products or coverages available through the wellness program shall not duplicate products or coverages available through the pet insurance policy;

(5) The advertising of the wellness program shall not be misleading and shall be in accordance with subsection (b) of this section; and

(6) A pet insurer and/or producer shall clearly disclose the following to consumers, printed in twelve-point (12-point) boldface type:

(i) That wellness programs are not insurance.

(ii) The address and customer service telephone number of the pet insurer or producer or

broker of record.

(c) Coverages included in the pet insurance policy contract described as "wellness" benefits are insurance.

27-82-7. Insurance producer training.

(a) An insurance producer shall not sell, solicit, or negotiate a pet insurance product until after the producer is appropriately licensed and has completed the required training identified in subsection (c) of this section.

(b) Insurers shall ensure that its producers are trained under subsection (c) of this section and that its producers have been appropriately trained on the coverages and conditions of its pet insurance products.

(c) The training required under this subsection shall include information on the following topics:

(1) Preexisting conditions and waiting periods;

(2) The differences between pet insurance and noninsurance wellness programs;

(3) Hereditary disorders, congenital anomalies or disorders and chronic conditions and how pet insurance policies interact with those conditions or disorders; and

(4) Rating, underwriting, renewal, and other related administrative topics.

(d) The satisfaction of the training requirements of another state that are substantially similar to the provisions of subsection (c) of this section shall be deemed to satisfy the training requirements in this state.

27-82-8. Violations.

Violations of this chapter shall be subject to penalties pursuant to § 42-14-16.

SECTION 10. Sections 1 through 3 and sections 5 through 9 of this act shall take effect on January 1, 2024, and section 4 shall take effect upon passage, provided:

(1) The provisions of this act in effect before the effective date of this act shall continue to apply to and govern all matters, including all past, present and future assessments, credits and refunds, relating to any member insurer that either:

(i) Was an insolvent insurer prior to the effective date of this act; or

(ii) Was an impaired insurer for which the association formally exercised its powers under § 27-34.3-8 to provide coverage to the policyholders of the impaired insurer prior to the effective date of this act; and

(2) The provisions of this act in effect on and after the effective date of this act shall apply to and govern all matters, including assessments, credits and refunds, relating to all insolvent

insurers and impaired insurers not identified in subsection (1) of this effective date section.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- PRODUCER LICENSING ACT

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This act would amend the statutory provisions regarding insurance producer appointments to provide for an efficient electronic process clarify language relating to insurance claims adjusters, add elements to unfair discrimination prohibitions, amend the Rhode Island life and health guarantee association act, and add an insurance data security act and a pet insurance act.

Sections 1 through 3 and sections 5 through 9 of this act would take effect on January 1, 2024 and section 4 would take effect upon passage, provided:

(1) The provisions of this act in effect before the effective date of this act would continue to apply to and govern all matters, including all past, present and future assessments, credits and refunds, relating to any member insurer that either:

(i) Was an insolvent insurer prior to the effective date of this act; or

(ii) Was an impaired insurer for which the association formally exercised its powers under § 27-34.3-8 to provide coverage to the policyholders of the impaired insurer prior to the effective date of this act; and

(2) The provisions of this act in effect on and after the effective date of this act would apply to and govern all matters, including assessments, credits and refunds, relating to all insolvent insurers and impaired insurers not identified in subsection (1) of this effective date section.

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