BILL ANALYSIS

Senate Research Center
79R17273 DLF-D

C.S.H.B. 2883
By: Smithee (Harris)
State Affairs
5/18/2005
Committee Report (Substituted)

AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

The Guaranty Act protects Texas policyholders against the insolvency of an insurance carrier and its subsequent inability to perform its contractual obligations under life, accident, health and annuity contracts. The legislature established this protection in 1973 by creating a mandatory association of all licensed insurers that write these lines of business in Texas. There are 745 companies writing life, accident and health insurance and annuity contracts in Texas.

The last comprehensive update of the Guaranty Act was in 1991. The current law was based on an older version of a model law developed by the National Association of Insurance Commissioners (NAIC). NAIC has revised and updated the model Act on at least five different occasions since 1991, including an increase of the coverage limits to provide greater consumer protections in the event of an insurer's failure. In addition, new insurance products have been introduced and innovations have been made in the marketing and sale of insurance products. Updating the Guaranty Act to respond to these changes will provide greater protection to policyholders and ease of administration, and clarify certain ambiguities within the current Guaranty Act. Updating the Guaranty Act would also help ensure uniform treatment of policyholders among the states because it would more closely align Texas laws with the guaranty acts of other states. Uniformity among the states produces a variety of desirable results, including decreasing the risk of litigation.

C.S.H.B. 2883 improves the efficiency of the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association's administration of insolvent insurance companies' policies and claims, introduces language to clarify definitions to eliminate ambiguities in the current law, and formalizes current Association practices in processing policyholder claims for benefits. The bill provides an update to address improved methods for assessing member insurers; enhancing coverage benefits available to Texas policyholders; and making coverage more equitable for entities that own insurance policies. This bill also incorporates the current revisions of the NAIC model act.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 3, Article 21.28-D, Insurance Code, as follows:

> Sec. 3. COVERAGE AND LIMITATIONS. (a) Provides that, subject to Subsections (a-1) and (a-2) of this section, this Act provides coverage for a policy or contract specified in Subsection (b) to a modified list of certain persons.
>
> (a-1) Provides that this Act does not provide coverage to certain persons.
>
> (a-2) Provides that this Act is intended to provide coverage to persons who are residents of this state, and in those limited circumstances as described in this Act, to nonresidents. Prohibits a person, in order to avoid duplicate coverage, if the person who would otherwise receive coverage under this Act is provided coverage under the laws of any other state, from being provided coverage under this Act. Requires this Act to be construed in conjunction with other state laws to

result in coverage by only one association in determining the application of the provisions of this subsection in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee.

(b) Provides that annuity contracts and certificates under group annuity contracts include certain contracts, including structured settlement annuities and annuities issued to or in connection with government lotteries. Makes conforming changes.

(c) Provides that this Act does not provide coverage for a modified list of certain policies.

(d) Provides that the Life, Accident, Health, and Hospital Service Insurance Guaranty Association (association) has no obligation to provide benefits outside the express written terms of the policy or contract, including claims based on certain information. Makes a nonsubstantive change.

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

SECTION 2. Amends Section 5, Article 21.28-D, Insurance Code, to redefine "association," "contractual obligation," "covered policy," "impaired insurer," "insolvent insurer," "member insurer," "person," "premiums," "resident," and "supplemental contract." Defines "benefit plan," "owner," "plan sponsor," and "structured settlement annuity."

SECTION 3. Amends Article 21.28-D, Insurance Code, by adding Section 5A, as follows:

Sec. 5A. DEFINITION OF PRINCIPAL PLACE OF BUSINESS OF PLAN SPONSOR OR OTHER PERSON. (a) Defines "principal place of business."

(b) Provides that, in the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state is the principal place of business of the plan sponsor.

(c) Provides that the principal place of business of a plan sponsor of a benefit plan described in Section 5(9-a)(C) of this article is 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, is required to be deemed to be the principal place of business of the employer or employee organization that has the largest investment in that benefit plan.

SECTION 4. Amends Section 6(a), Article 21.28-D, Insurance Code, to provide that the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association (association), rather than the Life, Accident, Health, and Hospital Service Insurance Guaranty Association, is a nonprofit legal entity.

SECTION 5. Amends Section 8, Article 21.28-D, Insurance Code, by amending Subsections (e), (n), and (v), and by adding Subsections (u-1), (u-2), (u-3), (x), and (y), as follows:

(e) Requires the association to assure payment of benefits for premiums identical to the premiums and benefits, except for terms of the conversion and renewability that would have been payable under the policies of the impaired or insolvent insurer, for certain claims.

(n) Makes a conforming change.

(u-1) Provides that the rights of the association under Subsection (u) include, 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 under this Act, against any person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for the annuity, other than a person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Section 130, Internal Revenue Code of 1986 (26 U.S.C. Section 130).

(u-2) Provides that, if a provision of Subsection (t), (u), or (u-1) of this section is 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 is reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion of the policies, covered by the association. Requires a person, if the association has provided benefits with respect to a covered obligation and the person recovers amounts as to which the association has rights described in Subsection (t), (u), or (u-1) of this section, to pay to the association the portion of the recovery attributable to the policies, or portion of the policies, covered by the association.

(u-3) Requires a deposit in this state, held under law or required by the commissioner of insurance for the benefit of creditors, including policy owners, that is not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or a reciprocal state in accordance with Section 13 (Ancillary Delinquency Proceedings), Article 21.28, of this code, to be promptly paid to the association. Entities the association to retain a portion of any amount paid to the association under this subsection equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount paid to the association and retained under this subsection. Provides that the amount paid to the association under this subsection, less the amount retained by the association under this subsection, is treated as a distribution of estate assets under Section 7A(a) (relating to early access distribution), Article 21.28, of this code, or the similar law of the state of domicile of the impaired or insolvent insurer.

(v) Authorizes the association to request information from a person seeking coverage from the association in determining its obligations under this Act with respect to the person, and requires the person to promptly comply with the request, and further authorizes the association to take any other necessary or appropriate action to discharge the association's duties and obligations under this Act or to exercise the association's powers under the Act.

(x) Requires the board of directors of the association to have discretion and authorizes the board to exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this Act in an economical and efficient manner.

(y) Provides that, if the association arranges or offers to provide the benefits of this Act to a covered person under a plan or arrangement that fulfills the association's obligations under this Act, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

SECTION 6. Amends Section 9, Article 21.28-D, Insurance Code, by amending Subsections (b), (d), (f), (g), and (h), and adding Subsection (b-1), as follows:

(b) Provides that Class A and Class B assessments are authorized and called, rather than made, for certain purposes.

(b-1) Provides that, for purposes of Subsection (b) of this section, an assessment is authorized at the time a resolution by the board of directors is passed under which an assessment will be called immediately or in the future from member insurers for a

specified amount and an assessment is called at the time a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within a period stated in the notice. Provides that an authorized assessment becomes a called assessment at the time notice is mailed by the association to member insurers.

(d) Requires the amount of a Class B assessment to be allocated, rather than divided, among the separate accounts in accordance with an allocation formula that are authorized to be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in the board's sole discretion as being fair and reasonable under the circumstances. Deletes existing text relating to dividing Class B assessments according to the annual statements for the preceding year.

(f) Requires Class B assessments against member insurers for each account to be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent bear to premiums received on business in this state for those calendar years by all assessed member insurers.

(g) Requires the association to notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called not later than the 180th day after the date the assessment is authorized. Makes a conforming change.

(h) Prohibits the total of all assessments on a member insurer for each account from exceeding two, rather than one, percent of the insurer's premiums on the policies covered by the account during the three, rather than in any one, calendar years preceding the year in which the insurer became an impaired or insolvent insurer. Requires the average annual premiums for purposes of the aggregate assessment percentage limitation described by this subsection, if two or more assessments are authorized in a calendar year with respect to insurers that become impaired or insolvent in different calendar years, to be equal to the higher of the three-year average annual premiums for the applicable subaccount or account as computed in accordance with this section.

SECTION 7. Amends Section 13(a), Article 21.28-D, Insurance Code, to require a member insurer, at its option, to have the right to show a certificate of contribution as an admitted assest in the form approved by the commissioner of insurance at percentages of the original face amount approved by the commissioner, for calendar years as follows:

100 percent for the calendar year of issuance, which is required to be reduced 20, rather than 10, percent a year for each year thereafter for a period of five, rather than 10, years.

SECTION 8. Amends Sections 14(d) and (i), Article 21.28-D, Insurance Code, to make conforming changes.

SECTION 9. (a) Provides that, effective September 1, 2005:

(1) the name of the Life, Accident, Health, and Hospital Service Insurance Guaranty Association is changed to the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association, and all powers, duties, rights, and obligations of the Life, Accident, Health, and Hospital Service Insurance Guaranty Association are the powers, duties, rights, and obligations of the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association;

(2) a member of the board of directors of the Life, Accident, Health, and Hospital Service Insurance Guaranty Association is a member of the board of directors of the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association; and

(3) a reference in law to the Life, Accident, Health, and Hospital Service Insurance Guaranty Association is a reference to the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association.

(b) Provides that the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association is the successor to the Life, Accident, Health, and Hospital Service Insurance Guaranty Association in all respects. Provides that all personnel, equipment, data, documents, facilities, contracts, items, other property, rules, decisions, and proceedings of or involving the Life, Accident, Health, and Hospital Service Insurance Guaranty Association are unaffected by the change in the name of the association.

SECTION 10. Makes application of this Act prospective.

SECTION 11. Effective date: September 1, 2005.