By: Smithee (Senate Sponsor - Harris) H.B. No. 2883

(In the Senate - Received from the House May 10, 2005; May 12, 2005, read first time and referred to Committee on State Affairs; May 19, 2005, reported adversely, with favorable Committee Substitute by the following vote: Yeas 8, Nays 0; May 19, 2005, sent to printer.)

COMMITTEE SUBSTITUTE FOR H.B. No. 2883 By: Harris

A BILL TO BE ENTITLED
AN ACT

relating to the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 3, Article 21.28-D, Insurance Code, is amended to read as follows:

Sec. 3. COVERAGE AND LIMITATIONS. (a) Subject to Subsections (a-1) and (a-2) of this section, this [~~This~~] Act provides coverage for a policy or contract specified in Subsection (b) of this section to the following persons:

(1) a person, other than a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee, or payee of a person covered under Paragraph (2) of this subsection; [~~and~~]

(2) a person who is an owner of or certificate holder under the policy or contract, other than [~~, or, in the case of~~] an unallocated annuity contract or structured settlement annuity, [~~to the person who is the contract holder,~~] and who:

(A) is a resident; or

(B) is not a resident, but only under all of the following conditions [~~if~~]:

(i) the insurers that issued the policies or contracts are domiciled in this state;

(ii) [~~the insurers never held a license or certificate of authority in the states in which the persons reside;~~

[~~(iii)~~] the state in which the person resides has an association [~~states have associations~~] similar to the association created by this Act; and

(iii) [~~(iv)~~] the person is not eligible for coverage by an association in any other state because the insurers were not licensed in the state at the time specified in that state's guaranty association law;

(3) a person who is the owner of an unallocated annuity contract issued to or in connection with:

(A) a benefit plan whose plan sponsor has the sponsor's principal place of business in this state; or

(B) a government lottery, if the owner is a resident; and

(4) a person who is the payee under a structured settlement annuity, or beneficiary of the payee if the payee is deceased, if:

(A) the payee is a resident, regardless of where the contract owner resides;

(B) the payee is not a resident, the contract owner of the structured settlement annuity is a resident, and the payee is not eligible for coverage by the association in the state in which the payee resides; or

(C) the payee and the contract owner are not residents, the insurer that issued the structured settlement annuity is domiciled in this state, the state in which the contract owner resides has an association similar to the association created by this Act, and neither the payee or, if applicable, the payee's beneficiary, nor the contract owner is eligible for coverage by the association in the state in which the payee or contract owner resides [~~the associations~~].

(a-1) This Act does not provide coverage to:

(1) a person who is a payee or the beneficiary of a payee with respect to a contract the owner of which is a resident of this state, if the payee or the payee's beneficiary is afforded any coverage by the association of another state; or

(2) a person otherwise described by Subsection (a)(3) of this section, if any coverage is provided by the association of another state to that person.

(a-2) 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. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Act is provided coverage under the laws of any other state, the person may not be provided coverage under this Act. 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, this Act shall be construed in conjunction with other state laws to result in coverage by only one association.

(b) This Act provides coverage to the persons specified in Subsection (a) of this section, and subject to Subsections (a-1) and (a-2) of this section, for direct, non-group life, health, accident, annuity, and supplemental policies or contracts, for certificates under direct group policies and contracts, group hospital service contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. This Act also provides coverage for all other insurance coverages written by mutual assessment corporations, local mutual aid associations, statewide mutual assessment companies, and stipulated premium companies licensed to do business in this state. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries [~~agreements, lottery contracts~~], and any immediate or deferred annuity contracts.

(c) This Act does not provide coverage for:

(1) a portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner [~~holder~~];

(2) a policy or contract of reinsurance, unless assumption certificates have been issued;

(3) a portion of a policy or contract to the extent that the rate of interest on which it is based:

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

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

(4) a portion of a policy or contract issued to a plan or program of an employer, association, [~~or~~] similar entity, or other person to provide life, health, or annuity benefits to its employees, [~~or~~] 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 similar entity under:

(A) a multiple employer welfare arrangement as defined by the Employee Retirement Income Security Act of 1974 (29

U.S.C. Section 1002);

(B) a minimum premium group insurance plan;

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

(D) an administrative services-only contract;

(5) a portion of a policy or contract, to the extent that it provides dividends or experience rating credits, voting rights, or provides that fees or allowances be paid to any person, including the policy or contract owner [~~holder~~], in connection with the service to or administration of the policy or contract;

(6) a policy or contract issued in this state by a member insurer at a time when it was not licensed to issue the policy or contract in this state;

(7) an unallocated annuity contract issued to or in connection with a [~~an employee~~] benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the Pension Benefit Guaranty Corporation has not yet become liable to make any payments with respect to the benefit plan;

(8) a portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, benefit plan for a union or association of natural persons, or a government lottery; [~~and~~]

(9) any portion of a financial guarantee, funding agreement, or guaranteed investment contract which (1) contains no mortality guarantees and (2) is not issued to or in connection with a specific employee, benefit plan, or a governmental lottery;

(10) a portion of a policy or contract to the extent that the assessments required by Section 9 of this Act with respect to the policy or contract are preempted by federal or state law;

(11) a contractual agreement that established 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 the plan's trustee in a case in which neither the benefit plan sponsor nor its trustee is an affiliate of the member insurer; and

(12) a portion of a policy or contract to the extent the policy or contract provides for interest or other changes in value that are to be determined by the use of an index or external reference stated in the policy or contract, but that 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 Act, whichever date is earlier; provided, however, if a policy's or contract's interest or changes in value are credited less frequently than annually, for purposes of determining the values that have been credited and are not subject to forfeiture as described by this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract is credited as if the contractual date of crediting interest or changing values is the earlier of the date of impairment or the date of insolvency, and is not subject to forfeiture.

(d) The benefits for which the association may become liable shall [~~may~~] not exceed the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer. The association has no obligation to provide benefits outside the express written terms of the policy or contract, including:

(1) claims based on marketing materials;

(2) claims based on side letters, riders, or other documents that were issued without meeting applicable policy form filing or approval requirements;

(3) claims based on misrepresentation of or regarding policy benefits;

(4) extracontractual claims; or

(5) claims for penalties or consequential or incidental damages.

(e) 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. The costs of the association's obligations under this Act may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to the association's subrogation and assignment rights.

SECTION 2. Section 5, Article 21.28-D, Insurance Code, is amended by amending Subdivisions (2), (3), (4), (5), (6), (7), (9), (10), (11), and (12) and adding Subdivisions (2-a), (8-a), (9-a), and (11-a) to read as follows:

(2) "Association" means the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association created under Section 6 of this Act.

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

(3) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 3 of this Act. A contractual obligation does not include:

(A) death benefits in an amount in excess of $300,000 or a net cash surrender or net cash withdrawal value in an amount in excess of $100,000 [~~in the aggregate~~] under one or more covered policies on any one life;

(B) an amount in excess of $100,000 in the present value [~~aggregate~~] under one or more annuity contracts within the scope of this Act issued with respect to one life under [~~to the same holder of~~] individual annuity policies or [~~to the same annuitant or participant under~~] group annuity policies or an amount in excess of $5,000,000 in unallocated annuity contract benefits with respect to any one contract holder irrespective of the number of such contracts;

(C) an amount in excess of the following amounts, including any net cash surrender or cash withdrawl values, [~~$200,000 in the aggregate~~] under one or more accident and health, accident, [~~or~~] health, or long-term care insurance policies on any one life:

(i) $500,000 for basic hospital, medical-surgical, or major medical insurance, as those terms are defined in this code or rules adopted by the commissioner;

(ii) $300,000 for disability and long-term care insurance, as those terms are defined in this code or rules adopted by the commissioner; or

(iii) $200,000 for coverages that are not defined as basic hospital, medical-surgical, major medical, disability, or long-term care insurance;

(D) an amount in excess of $100,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values, with respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b), or 457, Internal Revenue Code of 1986 (26 U.S.C. Sections 401, 403(b), and 457), covered by an unallocated annuity contract or the beneficiary or beneficiaries of the individual if the individual is deceased;

(E) an amount in excess of $100,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values, with respect to each payee of a structured settlement annuity or the beneficiary or beneficiaries of the payee if the payee is deceased;

(F) aggregate benefits in an amount in excess of $300,000 with respect to one life, except with respect to:

(i) benefits paid under basic hospital, medical-surgical, or major medical insurance policies, described by Paragraph (C)(i) of this subdivision, in which case the aggregate benefits are $500,000; and

(ii) benefits paid to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, in which case the maximum benefits are $5,000,000 regardless of the number of policies and contracts held by the

owner;

(G) an amount in excess of $5,000,000 in benefits, with respect to either one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in Paragraph (D) of this subdivision irrespective of the number of contracts with respect to the contract owner or plan sponsor or one contract owner provided coverage under Section 3(a)(3)(B) of this Act, except that, if one or more unallocated annuity contracts are covered contracts under this Act and are owned by a trust or other entity for the benefit of two 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 $5,000,000 in benefits with respect to all these unallocated contracts;

(H) any contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic value of economic benefits of the covered policy or contract; or

(I) [~~(D)~~] punitive, exemplary, extracontractual, or bad faith damages, whether agreed to or assumed by an insurer or insured or imposed by a court of competent jurisdiction.

(4) "Covered policy" means any policy or contract, or portion of a policy or contract, within the scope of this Act under Section 3 of this Act.

(5) "Impaired insurer" means[~~:~~

[~~(A)~~] a member insurer that is designated an "impaired insurer" by the commissioner and is:

(A) placed by a court in this state or another state [~~the commissioner~~] under an order of supervision, liquidation, rehabilitation, or conservation;

(B) placed under an order of liquidation or rehabilitation under the provisions of Article 21.28 of this code; or

(C) placed under an order of supervision or conservation by the commissioner under the provisions of Article 21.28-A of this code [~~or 21.28-A, Insurance Code, and that has been designated an "impaired insurer" by the commissioner; or~~

[~~(B) a member insurer determined in good faith by the commissioner to be unable or potentially unable to fulfill its contractual obligations~~].

(6) "Insolvent insurer" means a member insurer [~~whose minimum free surplus, if a mutual company, or whose required capital, if a stock company, becomes impaired to the extent prohibited by law and~~] that has been placed under an order of liquidation with a finding of insolvency [~~designated an "insolvent insurer"~~] by a court in this state or another state [~~the commissioner~~].

(7) "Member insurer" means any insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 3 of this Act, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, including a mutual assessment corporation, a local mutual association, a statewide mutual assessment company, and a stipulated premium company licensed to do business in this state, but does not include:

(A) a health maintenance organization;

(B) a fraternal benefit society;

(C) a mandatory state pooling plan;

(D) an insurance exchange; [~~or~~]

(E) an organization which has a certificate of authority or license limited to the issuance of charitable gift annuities as defined in this code or rules adopted by the commissioner; or

(F) any entity similar to any of those described by Paragraphs (A)-(E) [~~(A)-(D)~~] of this subdivision.

(8-a) "Owner" means the owner of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and is properly recorded as the owner on the books of the insurer. The terms owner, contract owner, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

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

(9-a) "Plan sponsor" means:

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

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

(C) in a case of a benefit plan established or maintained by two 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.

(10) "Premiums" means amounts received on covered policies or contracts less premiums, considerations, and deposits returned on those policies or contracts, and less dividends and experience credits on those policies or contracts. "Premiums" does not include amounts received for policies or contracts or for the portions of any policies or contracts for which coverage is not provided under Section 3(b) of this Act, except that assessable premiums shall not be reduced on account of Section 3(c)(3) of this Act relating to interest limitations and Section 5(3) of this Act relating to limitations with respect to any one individual, any one participant, any one annuitant, and any one contract owner [~~holder~~]. "Premiums" does not include premiums in excess of $5,000,000 [~~five million dollars~~] on any unallocated annuity contract not issued under a governmental benefit [~~retirement~~] plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code (26 U.S.C. Sections 401, 403(b) and 457). "Premiums" does not include premiums in excess of $5,000,000 with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, regardless of the number of policies or contracts held by the owner. "Premiums" also does not include premiums received from the Treasury of the State of Texas or from the Treasury of the United States for insurance contracted for by the state or federal government for the purpose of providing welfare benefits to designated welfare recipients or for insurance contracted for by the state or federal government in accordance with or in furtherance of the provisions of Title 2, Human Resources Code, or the Federal Social Security Act.

(11) "Resident" means any person who resides in this state on the earlier of the date a member insurer becomes an impaired insurer or the date of entry of a court order that determines a member insurer to be an impaired insurer or the date of entry of a court order that determines a member insurer to be an insolvent insurer [~~at the time a member insurer is determined to be an impaired or insolvent insurer~~] and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person is its principal place of business. A United States citizen that is either a resident of a foreign country or a resident of a United States possession, territory, or protectorate that does not have an association similar to the association created by this Act is considered a resident of the state of domicile of the insurer that issued the policy or contract.

(11-a) "Structured settlement annuity" means an

annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(12) "Supplemental contract" means any written agreement entered into for the distribution of policy or contract proceeds.

SECTION 3. Article 21.28-D, Insurance Code, is amended by adding Section 5A to read as follows:

Sec. 5A. DEFINITION OF PRINCIPAL PLACE OF BUSINESS OF PLAN SPONSOR OR OTHER PERSON. (a) Except as otherwise provided by this section, in this Act, the "principal place of business" of a plan sponsor or a person other than an individual means the single state in which the individuals who establish policy for the direction, control, and coordination of the operations of the plan sponsor or person as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the following factors:

(1) the state in which the primary executive and administrative headquarters of the plan sponsor or person is located;

(2) the state in which the principal office of the chief executive officer of the plan sponsor or person is located;

(3) the state in which the board of directors, or similar governing person or persons, of the plan sponsor or person conduct the majority of their meetings;

(4) the state in which the executive or management committee of the board of directors, or similar governing person or persons, of the plan sponsor or person conduct the majority of their meetings;

(5) the state from which the management of the overall operations of the plan sponsor or person is directed; and

(6) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors described by Subdivisions (1)-(5) of this subsection.

(b) 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) The principal place of business of a plan sponsor of a benefit plan described in Section 5(9-a)(C) of this Act 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, shall 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. Section 6(a), Article 21.28-D, Insurance Code, is amended to read as follows:

(a) The Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association is a nonprofit legal entity. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under Section 10 of this Act and shall exercise its powers through a board of directors established under Section 7 of this Act. For purposes of administration and assessment, the association shall maintain four accounts:

(1) the accident, health, and hospital services insurance account;

(2) the life insurance account;

(3) the annuity account; and

(4) the administrative account.

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

(e) When proceeding under Subsections (b)(2) or (d) of this section, with respect to only life and health insurance policies

the association shall:

(1) 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 of the impaired or insolvent insurer, for claims incurred:

(A) with respect to a group policy or contract, the later of:

(i) the earlier of the next renewal date under the policy or contract or the 45th day after the date the association becomes obligated with respect to the policy; or

(ii) the 30th day after the date the association becomes obligated with respect to the policy; or

(B) with respect to an individual policy, the later of:

(i) the earlier of the next renewal date under the policy, if any, or the date one year after the date the association becomes obligated with respect to the policy; or

(ii) the 30th day after the date the association becomes obligated with respect to the policy;

(2) make diligent efforts to provide all known insureds or group policyholders notice before the 30th day before the benefits provided are terminated; and

(3) with respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, substitute coverage on an individual basis in accordance with the provisions of Subsection (f) of this section, if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(n) Premiums due for coverage after entry of an order of receivership of an impaired or insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(u-1) 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) 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. If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights described in Subsection (t), (u), or (u-1) of this section, the person shall pay to the association the portion of the recovery attributable to the policies, or portion of the policies, covered by the association.

(u-3) A deposit in this state, held under law or required by the commissioner 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, Article 21.28, of this code, shall be promptly paid to the association. The association is entitled 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. 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), Article 21.28, of this code, or the similar law of the state of domicile of the impaired or insolvent insurer.

(v) The association may:

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

(2) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 9 of this Act and to settle claims or potential claims against it;

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

(4) employ or retain employees or contractors to handle the financial transactions of the association and to perform other functions under this Act;

(5) take legal action as may be necessary to avoid payment of improper claims; [~~and~~]

(6) exercise, for the purposes of this Act and to the extent approved by the commissioner, the powers of a domestic life, accident, health, or hospital service insurer, but the association may not issue insurance policies or annuity contracts other than those issued to perform its obligations under this Act;

(7) request information from a person seeking coverage from the association in determining its obligations under this Act with respect to the person, and the person shall promptly comply with the request; and

(8) 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 this Act.

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

(y) 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. Section 9, Article 21.28-D, Insurance Code, is amended by amending Subsections (b), (d), (f), (g), and (h) and adding Subsection (b-1) to read as follows:

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

(1) Class A assessments are authorized and called [~~made~~] to meet administrative costs of the association, administrative expenses properly incurred under this Act relating to any unauthorized insurer or nonmember of the association, and other general expenses not related to a particular insolvent or impaired insurer; and

(2) Class B assessments are authorized and called [~~made~~] to the extent necessary to carry out the powers and duties of the association under Section 8 with regard to an insolvent or impaired insurer.

(b-1) 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. An authorized assessment becomes a called assessment at the time

notice is mailed by the association to member insurers.

(d) The amount of a Class B assessment shall be allocated [~~divided~~] among the separate accounts in accordance with an allocation formula that may be based on:

(1) the premiums or reserves of the impaired or insolvent insurer; or

(2) any other standard deemed by the board of directors in the board's sole discretion as being fair and reasonable under the circumstances [~~as reflected in the annual statements for the year preceding the assessment in the same proportion that the premiums from the policies covered by each account were received by the insolvent or impaired insurer from all covered policies during the year preceding impairment~~].

(f) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on [~~all~~] 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 [~~the~~] premiums received on [~~all~~] business in this state for those calendar years by all assessed member insurers.

(g) Assessments for funds to meet the requirements of the association with respect to an insolvent or impaired insurer may not be authorized and called [~~made~~] until necessary to implement the purposes of this Act. Classification of assessments under Subsection (b) of this section and computation of assessments under this section 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 not later than the 180th day after the date the assessment is authorized.

(h) The association may defer, in whole or in part, the assessment of a member insurer if, in the opinion of the association, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. The total of all assessments on a member insurer for each account may not exceed two [~~one~~] percent of the insurer's premiums on the policies covered by the account during the three [~~in any one~~] calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If two or more assessments are authorized in a calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation described by this subsection shall 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. Section 13(a), Article 21.28-D, Insurance Code, is amended to read as follows:

(a) Unless a longer period of time has been required by the commissioner, a member insurer shall at its option have the right to show a certificate of contribution as an admitted asset in the form approved by the commissioner under Section 9(k) of this Act 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 shall be reduced 20 [~~10~~] percent a year for each year thereafter for a period of 5 [~~10~~] years.

SECTION 8. Sections 14(d) and (i), Article 21.28-D, Insurance Code, are amended to read as follows:

(d) Before the termination of any receivership, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policyholders of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired or insolvent insurer. In making this determination, the court shall consider the welfare of the policyholders of the continuing or successor insurer.

(i) The maximum amount recoverable under Subsections (f)

and (h) of this section is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer.

SECTION 9. (a) 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) 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. 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. The change in law made by this Act applies only to an insurer that first becomes an impaired or insolvent insurer on or after the effective date of this Act. An insurer that becomes an impaired or insolvent insurer before the effective date of this Act is governed by the law as it existed immediately before that date, and that law is continued in effect for this purpose.

SECTION 11. This Act takes effect September 1, 2005.

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