By: Smithee H.B. No. 1864

A BILL TO BE ENTITLED

AN ACT

relating to the Texas Life and Health Insurance Guaranty Association.

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

SECTION 1. Section 463.002, Insurance Code, is amended to read as follows:

Sec. 463.002. PURPOSE. The purpose of this chapter is to protect, subject to certain limitations, a person specified by Section 463.201 against failure in the performance of a contractual obligation under a life, accident, [~~or~~] health, [~~insurance policy~~] or annuity policy, plan, or contract with respect to which this chapter provides coverage as determined under Subchapter E, because of the impairment or insolvency of the member insurer that issued the policy, plan, or contract.

SECTION 2. Section 463.003, Insurance Code, is amended by amending Subdivisions (4), (7-a), and (9) and adding Subdivisions (4-a), (4-b), (5-a), and (6-a) to read as follows:

(4) "Covered policy" or "covered contract" means a policy or contract, or portion of a policy or contract, including a health maintenance organization contract, with respect to which this chapter provides coverage as determined under Subchapter E.

(4-a) "Enrollee" means an individual who is enrolled in a health maintenance organization contract with respect to which this chapter provides coverage as determined under Subchapter E.

1 For purposes of this chapter, an enrollee is considered to be an
2 insured.
3 (4-b) "Health benefit plan" means a hospital and
4 medical expense incurred policy or certificate, health maintenance
5 organization enrollee contract, or any other similar health
6 contract. The term does not include:
7 (A) accident-only insurance;
8 (B) credit insurance;
9 (C) dental-only insurance;
10 (D) vision-only insurance;
11 (E) Medicare supplement insurance;
12 (F) long-term care coverage or benefits, home
13 health care coverage or benefits, community-based care coverage or
14 benefits, or any combination of those coverages or benefits;
15 (G) disability income insurance;
16 (H) coverage for on-site medical clinics; or
17 (I) specified disease, hospital confinement
18 indemnity, or limited benefit health insurance coverage if the
19 types of coverage do not provide coordination of benefits and are
20 provided under separate policies or certificates.
21 (5-a) "Insurance" includes health benefit plan
22 coverage.
23 (6-a) "Insurer" includes a health maintenance
24 organization.
25 (7-a) "Owner" means the owner of a policy or contract
26 and "policyholder," "policy owner," and "contract owner" mean the
27 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 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.

(9) "Premium" means an amount received on a covered policy, less any premium, consideration, or deposit returned on the policy, and any dividend or experience credit on the policy. The term does not include:

(A) an amount received for a policy or contract or part of a policy or contract for which coverage is not provided under Section 463.202, except that assessable premiums may not be reduced because of:

(i) an interest limitation provided by Section 463.203(b)(3); or

(ii) a limitation provided by Section 463.204 with respect to a single individual, participant, annuitant, or policy or contract owner;

(B) premiums in excess of $5 million on an unallocated annuity contract not issued under a governmental benefit plan established under Section 401, 403(b), or 457, Internal Revenue Code of 1986;

(C) premiums received from the state treasury or the United States treasury for insurance for which this state or the United States contracts to:

1 (i) provide welfare benefits to designated
2 welfare recipients; or
3 (ii) implement:
4 (a) Title 2, Health and Safety Code;
5 (b) Title 2, Human Resources Code; [,]
6 or
7 (c) the Social Security Act (42 U.S.C.
8 Section 301 et seq.); or
9 (D) premiums in excess of $5 million with respect
10 to multiple nongroup policies of life insurance owned by one owner,
11 regardless of whether the policy owner is an individual, firm,
12 corporation, or other person and regardless of whether the persons
13 insured are officers, managers, employees, or other persons,
14 regardless of the number of policies or contracts held by the owner.
15 SECTION 3. Subchapter A, Chapter 463, Insurance Code, is
16 amended by adding Sections 463.0032 and 463.007 to read as follows:
17 Sec. 463.0032. USE OF TERMS POLICY AND CONTRACT. For
18 purposes of this chapter, "policy" and "contract" have the same
19 meaning.
20 Sec. 463.007. CONSTRUCTION OF LONG-TERM CARE RIDER. For
21 purposes of this chapter, benefits provided by a long-term care
22 rider to a life insurance policy or annuity contract are considered
23 to be the same type of benefits as the base life insurance policy or
24 annuity contract.
25 SECTION 4. Section 463.052, Insurance Code, is amended to
26 read as follows:
27 Sec. 463.052. REQUIRED PARTICIPATION IN ASSOCIATION. (a)

As a condition of engaging in the business of insurance in this state, an insurer, including a mutual assessment company, a local mutual aid association, a statewide mutual assessment company, [and] a stipulated premium company, and a health maintenance organization authorized to engage in business in this state, shall participate as a member of the association if the insurer holds a certificate of authority to engage in a kind of insurance business in this state with respect to which this chapter provides coverage as determined under Subchapter E. The requirement to participate applies regardless of whether the insurer's certificate of authority in this state is suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The following do not participate as member insurers:

(1) [a health maintenance organization;

[(2)] a fraternal benefit society;

(2) [(3)] a mandatory state pooling plan;

(3) [(4)] a reciprocal or interinsurance exchange;

(4) [(5)] an organization which has a certificate of authority or license limited to the issuance of charitable gift annuities, as defined by this code or rules adopted by the commissioner; and

(5) [(6)] an entity similar to an entity described by Subdivision (1), (2), (3), or (4)[, or (5)].

SECTION 5. Section 463.053, Insurance Code, is amended by adding Subsection (c-1) to read as follows:

(c-1) The commissioner shall consider, among other things, whether the directors appointed under Subsections (b) and (c)

fairly represent the member insurers that are health maintenance organizations and life, health, and annuity insurers.

SECTION 6. Sections 463.059(a), (c), and (f), Insurance Code, are amended to read as follows:

(a) Notwithstanding Chapter 551, Government Code, or any other law, the board or a committee of the board may meet by telephone conference call, videoconference, or other similar telecommunication method [~~if immediate action is required and convening a quorum of the board or committee of the board at a single location is not reasonable or practical. A board or committee member who is unable to attend a meeting in person and who is participating in a board or committee meeting by telephone conference call, videoconference, or other similar telecommunication method may be counted to establish a quorum and may vote~~]. The board may use telephone conference call, videoconference, or other similar telecommunication method for establishing a quorum, voting, or any other meeting purpose in accordance with this section regardless of the subject matter discussed or considered by the board at the meeting.

(c) The notice of a meeting authorized by this section must specify [~~that~~] the location of the meeting [~~is the location at which meetings of the board and committees of the board are usually held~~].

(f) An audio or digital recording of a meeting authorized by this section must be made in accordance with the association's bylaws. The recording of the open portion of the meeting must be posted on the association's Internet website [~~made available to the public~~].

1 SECTION 7. Section 463.101(a), Insurance Code, is amended
2 to read as follows:
3 (a) The association may:
4 (1) enter into contracts as necessary or proper to
5 carry out this chapter and the purposes of this chapter;
6 (2) sue or be sued, including taking:
7 (A) necessary or proper legal action to:
8 (i) recover an unpaid assessment under
9 Subchapter D; or
10 (ii) settle a claim or potential claim
11 against the association; or
12 (B) necessary legal action to avoid payment of an
13 improper claim;
14 (3) borrow money to effect the purposes of this
15 chapter;
16 (4) exercise, for the purposes of this chapter and to
17 the extent approved by the commissioner, the powers of a domestic
18 life, accident, or health insurance company, a health maintenance
19 organization, or a group hospital service corporation, except that
20 the association may not issue an insurance policy or annuity
21 contract other than to perform the association's obligations under
22 this chapter;
23 (5) unless prohibited by other law, implement or file
24 for an actuarially justified rate or premium increase in accordance
25 with the terms and conditions of a covered policy or contract;
26 (6) to further the association's purposes, exercise
27 the association's powers, and perform the association's duties,

join an organization of one or more state associations that have similar purposes;

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

(8) [(7)] take any other necessary or appropriate action to discharge the association's duties and obligations under this chapter or to exercise the association's powers under this chapter.

SECTION 8. Section 463.102(b), Insurance Code, is amended to read as follows:

(b) The association may amend the plan of operation. An amendment must be approved by the commissioner and takes effect on:

(1) the date the commissioner approves the amendment; or

(2) the 60th [30th] day after the date the amendment is submitted to the commissioner for approval, if the commissioner does not approve or disapprove the amendment before the 60th [30th] day.

SECTION 9. Section 463.109, Insurance Code, is amended to read as follows:

Sec. 463.109. ASSOCIATION APPEARANCE BEFORE COURT; INTERVENTION. (a) The association may appear before a court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter. The association's right to appear applies to:

(1) a proposal for reinsuring, reissuing, modifying, or guaranteeing the insurer's policies or contracts;

(2) the determination of the insurer's policies or contracts and contractual obligations; and

(3) any other matter germane to the association's powers and duties.

(b) The association may appear or intervene before a court in another state with jurisdiction over:

(1) an impaired or insolvent insurer concerning which the association is or may become obligated; or

(2) a third party against whom the association may have rights through subrogation of the insurer's policyholders or enrollees.

SECTION 10. Sections 463.114(c), (d), and (e), Insurance Code, are amended to read as follows:

(c) At the expiration of the 60th day after approval of the document, a member [~~an~~] insurer may not deliver a policy or contract with respect to which this chapter provides coverage as determined under Subchapter E to a policy, [~~or~~] contract, or certificate holder or enrollee before a copy of the summary document is delivered to the policy, [~~or~~] contract, or certificate holder or enrollee. The document must also be available on request of a policy, contract, or certificate holder or enrollee [~~policyholder~~].

(d) The distribution, delivery, content, or interpretation of a summary document does not guarantee that a policy or contract or a policy, [~~or~~] contract, or certificate holder or enrollee is

1 provided coverage by this chapter if a member insurer becomes
2 impaired or insolvent. Failure to receive the document does not
3 give an insured or policy, contract, or certificate holder or
4 enrollee any rights greater than those provided by this chapter.
5 (e) An insurer or agent may not deliver a policy or contract
6 described by Section 463.202 that is excluded from the coverage
7 provided by this chapter by Section 463.203 unless the insurer or
8 agent, either before or in conjunction with delivery, gives the
9 policy, [or] contract, or certificate holder or enrollee a separate
10 written notice clearly and conspicuously disclosing that the policy
11 or contract is not covered by the association.
12 SECTION 11. Section 463.153, Insurance Code, is amended by
13 amending Subsections (b) and (c) and adding Subsection (b-1) to
14 read as follows:
15 (b) Class B assessments on [against] a member insurer for
16 each account under Section 463.105 shall be authorized and called
17 in the proportion that the premiums received on business in this
18 state by the member insurer on policies or contracts covered by each
19 account for the three most recent calendar years for which
20 information is available preceding the year in which the impaired
21 or insolvent member insurer became impaired or insolvent bear to
22 premiums received on business in this state for those calendar
23 years by all assessed member insurers. Except for assessments
24 related to long-term care insurance as described by Subsection
25 (b-1), the [The] amount of a Class B assessment shall be allocated
26 among the separate accounts in accordance with an allocation
27 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 in the board's sole discretion as being fair and reasonable under the circumstances.

(b-1) The amount of a Class B assessment for long-term care insurance written by an impaired or insolvent member insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers. This subsection does not apply to a rider to a member insurer's life insurance policy or annuity contract that provides long-term care benefits.

(c) The total amount of assessments on a member insurer for each account under Section 463.105 may not in one calendar year exceed two percent of the insurer's average annual premiums on the policies covered by the account during the three calendar years preceding the year in which the impaired or insolvent member insurer became an impaired or insolvent insurer. If two or more assessments are authorized in a 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 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. If the maximum

assessment and the other assets of the association do not provide in a year an amount sufficient to carry out the association's responsibilities, the association shall make necessary additional assessments as soon as this chapter permits.

SECTION 12. Sections 463.154 and 463.201, Insurance Code, are amended to read as follows:

Sec. 463.154. DEFERMENT. The association may wholly or partly defer an assessment on [~~of~~] a member insurer if the association believes payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. The amount of the assessment that is deferred may be assessed against the other member insurers in a manner consistent with this subchapter.

Sec. 463.201. PERSONS [~~INSUREDS~~] COVERED. (a) Subject to Subsections (b) and (c), this chapter provides coverage for a policy or contract described by Section 463.202 to a person who is:

(1) a person, other than a certificate holder under a group policy or contract who is not a resident, who is a beneficiary, assignee, or payee, including a health care provider who renders services covered under a health insurance policy or certificate, of a person described by Subdivision (2);

(2) a person who is an owner of or certificate holder or enrollee under a policy or contract specified by Section 463.202, other than an unallocated annuity contract or structured settlement annuity, and who is:

(A) a resident; or

(B) not a resident, but only under all of the

1 following conditions:
2 (i) the <u>member</u> insurers that issued the
3 policies or contracts are domiciled in this state;
4 (ii) the state in which the person resides
5 has an association similar to the association; and
6 (iii) the person is not eligible for
7 coverage by an association in any other state because the insurer <u>or</u>
8 <u>health maintenance organization</u> was not licensed in the state at
9 the time specified in that state's guaranty association law;
10 (3) a person who is the owner of an unallocated annuity
11 contract issued to or in connection with:
12 (A) a benefit plan whose plan sponsor has the
13 sponsor's principal place of business in this state; or
14 (B) a government lottery, if the owner is a
15 resident; or
16 (4) a person who is the payee under a structured
17 settlement annuity, or beneficiary of the payee if the payee is
18 deceased, if:
19 (A) the payee is a resident, regardless of where
20 the contract owner resides;
21 (B) the payee is not a resident, the contract
22 owner of the structured settlement annuity is a resident, and the
23 payee is not eligible for coverage by the association in the state
24 in which the payee resides; or
25 (C) the payee and the contract owner are not
26 residents, the insurer that issued the structured settlement
27 annuity is domiciled in this state, the state in which the contract

1 owner resides has an association similar to the association, and
2 neither the payee or, if applicable, the payee's beneficiary, nor
3 the contract owner is eligible for coverage by the association in
4 the state in which the payee or contract owner resides.
5 (b) This chapter does not provide coverage to:
6 (1) a person who is a payee or the beneficiary of a
7 payee with respect to a contract the owner of which is a resident of
8 this state, if the payee or the payee's beneficiary is afforded any
9 coverage by the association of another state; [~~or~~]
10 (2) a person otherwise described by Subsection (a)(3),
11 if any coverage is provided by the association of another state to
12 that person; or
13 (3) a person who acquires rights to receive payments
14 through a structured settlement factoring transaction as defined by
15 Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C.
16 Section 5891(c)(3)(A)), regardless of whether the transaction
17 occurred before, on, or after the date that section became
18 effective.
19 (c) This chapter is intended to provide coverage to persons
20 who are residents of this state, and in those limited circumstances
21 as described in this chapter, to nonresidents. In order to avoid
22 duplicate coverage, if a person who would otherwise receive
23 coverage under this chapter is provided coverage under the laws of
24 any other state, the person may not be provided coverage under this
25 chapter. In determining the application of the provisions of this
26 subsection in situations in which a person could be covered by the
27 association of more than one state, whether as an owner, payee,

1 enrollee, beneficiary, or assignee, this chapter shall be construed
2 in conjunction with other state laws to result in coverage by only
3 one association.
4 SECTION 13. Section 463.202(a), Insurance Code, is amended
5 to read as follows:
6 (a) Except as limited by this chapter, the coverage provided
7 by this chapter to a person specified by Section 463.201, subject to
8 Sections 463.201(b) and (c), applies with respect to the following
9 policies and contracts issued by a member insurer:
10 (1) a direct, nongroup life, health, accident,
11 annuity, or supplemental policy or contract, including a health
12 maintenance organization contract or certificate;
13 (2) a certificate under a direct group policy or
14 contract;
15 (3) a group hospital service contract; and
16 (4) an unallocated annuity contract.
17 SECTION 14. Section 463.203, Insurance Code, is amended by
18 amending Subsection (b) and adding Subsection (b-1) to read as
19 follows:
20 (b) This chapter does not provide coverage for:
21 (1) any part of a policy or contract not guaranteed by
22 the insurer or under which the risk is borne by the policy or
23 contract owner;
24 (2) a policy or contract of reinsurance, unless an
25 assumption certificate has been issued;
26 (3) any part of a policy or contract to the extent that
27 the rate of interest on which that part is based:

1 (A) as averaged over the period of four years
2 before the date the member insurer becomes impaired or insolvent
3 under this chapter, whichever is earlier, exceeds a rate of
4 interest determined by subtracting two percentage points from
5 Moody's Corporate Bond Yield Average averaged for the same
6 four-year period or for a lesser period if the policy or contract
7 was issued less than four years before the date the member insurer
8 becomes impaired or insolvent under this chapter, whichever is
9 earlier; and
10 (B) on and after the date the member insurer
11 becomes impaired or insolvent under this chapter, whichever is
12 earlier, exceeds the rate of interest determined by subtracting
13 three percentage points from Moody's Corporate Bond Yield Average
14 as most recently available;
15 (4) a portion of a policy or contract issued to a plan
16 or program of an employer, association, similar entity, or other
17 person to provide life, health, or annuity benefits to the entity's
18 employees, members, or others, to the extent that the plan or
19 program is self-funded or uninsured, including benefits payable by
20 an employer, association, or similar entity under:
21 (A) a multiple employer welfare arrangement as
22 defined by Section 3, Employee Retirement Income Security Act of
23 1974 (29 U.S.C. Section 1002);
24 (B) a minimum premium group insurance plan;
25 (C) a stop-loss group insurance plan; or
26 (D) an administrative services-only contract;
27 (5) any part of a policy or contract to the extent that

the part provides dividends, experience rating credits, or voting rights, or provides that fees or allowances be paid to any person, including the policy or contract owner, 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 the insurer was not authorized to issue the policy or contract in this state;

(7) 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 Pension Benefit Guaranty Corporation has not yet become liable to make any payments with respect to the benefit plan;

(8) any part of an unallocated annuity contract that is not issued to or in connection with a specific employee, a benefit plan for a union or association of individuals, or a governmental lottery;

(9) any part of a financial guarantee, funding agreement, or guaranteed investment contract that:

(A) does not contain a mortality guarantee; and

(B) is not issued to or in connection with a specific employee, a benefit plan, or a governmental lottery;

(10) a part of a policy or contract to the extent that the assessments required by Subchapter D 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

1 reference to a portfolio of assets that is owned by the benefit plan
2 or the plan's trustee in a case in which neither the benefit plan
3 sponsor nor its trustee is an affiliate of the member insurer;
4 (12) a part of a policy or contract to the extent the
5 policy or contract provides for interest or other changes in value
6 that are to be determined by the use of an index or external
7 reference stated in the policy or contract, but that have not been
8 credited to the policy or contract, or as to which the policy or
9 contract owner's rights are subject to forfeiture, as of the date
10 the member insurer becomes an impaired or insolvent insurer under
11 this chapter, whichever date is earlier, subject to Subsection (c);
12 [~~or~~]
13 (13) a policy or contract providing a hospital,
14 medical, prescription drug, or other health care benefit under 42
15 U.S.C. Sections 1395w-21 et seq. and 1395w-101 et seq. (Medicare
16 Parts C and D), 42 U.S.C. Sections 1396-1396w-5 (Medicaid), or 42
17 U.S.C. Sections 1397aa-1397mm (State Children's Health Insurance
18 Program) or a regulation adopted under those federal statutes; or
19 (14) structured settlement annuity benefits to which a
20 payee or beneficiary has transferred the payee's or beneficiary's
21 rights in a structured settlement factoring transaction as defined
22 by Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C.
23 Section 5891(c)(3)(A)), regardless of whether the factoring
24 transaction occurred before, on, or after the date that section
25 became effective.
26 (b-1) The exclusion from coverage described by Subsection
27 (b)(3) does not apply to any portion of a policy or contract,

1 including a rider, that provides long-term care benefits or any
2 other health insurance benefit.
3 SECTION 15. Section 463.204, Insurance Code, is amended to
4 read as follows:
5 Sec. 463.204. OBLIGATIONS EXCLUDED. A contractual
6 obligation does not include:
7 (1) death benefits in an amount in excess of $300,000
8 or a net cash surrender or net cash withdrawal value in an amount in
9 excess of $100,000 under one or more life insurance policies on a
10 single life;
11 (2) an amount in excess of:
12 (A) $250,000 in the present value under one or
13 more annuity contracts issued with respect to a single life under
14 individual annuity policies or group annuity policies; or
15 (B) $5 million in unallocated annuity contract
16 benefits with respect to a single contract owner regardless of the
17 number of those contracts;
18 (3) an amount in excess of the following amounts,
19 including any net cash surrender or cash withdrawal values, under
20 one or more accident, health, accident and health, or long-term
21 care insurance policies on a single life:
22 (A) $500,000 for health benefit plans [~~basic~~
23 ~~hospital, medical-surgical, or major medical insurance, as those~~
24 ~~terms are defined by this code or rules adopted by the~~
25 ~~commissioner~~];
26 (B) $300,000 for disability income and long-term
27 care insurance, as those terms are defined by this code or rules

adopted by the commissioner; or

(C) $200,000 for coverages that are not defined as health benefit plans [~~basic hospital, medical-surgical, major medical~~], disability income, or long-term care insurance;

(4) an amount in excess of $250,000 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;

(5) an amount in excess of $250,000 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;

(6) aggregate benefits in an amount in excess of $300,000 with respect to a single life, except with respect to:

(A) benefits paid under health benefit plans [~~basic hospital, medical-surgical, or major medical insurance policies~~], described by Subdivision (3)(A), in which case the aggregate benefits are $500,000; and

(B) 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

1 persons, in which case the maximum benefits are $5 million
2 regardless of the number of policies and contracts held by the
3 owner;
4 (7) an amount in excess of $5 million in benefits, with
5 respect to either one plan sponsor whose plans own directly or in
6 trust one or more unallocated annuity contracts not included in
7 Subdivision (4) irrespective of the number of contracts with
8 respect to the contract owner or plan sponsor or one contract owner
9 provided coverage under Section 463.201(a)(3)(B), except that, if
10 one or more unallocated annuity contracts are covered contracts
11 under this chapter and are owned by a trust or other entity for the
12 benefit of two or more plan sponsors, coverage shall be afforded by
13 the association if the largest interest in the trust or entity
14 owning the contract or contracts is held by a plan sponsor whose
15 principal place of business is in this state, and in no event shall
16 the association be obligated to cover more than $5 million in
17 benefits with respect to all these unallocated contracts;
18 (8) any contractual obligations of the insolvent or
19 impaired insurer under a covered policy or contract that do not
20 materially affect the economic value of economic benefits of the
21 covered policy or contract; or
22 (9) punitive, exemplary, extracontractual, or bad
23 faith damages, regardless of whether the damages are:
24 (A) agreed to or assumed by an insurer, [~~or~~]
25 insured, or covered person; or
26 (B) imposed by a court.
27 SECTION 16. Section 463.251(b), Insurance Code, is amended

1 to read as follows:
2 (b) With the commissioner's approval, the association may:
3 (1) guarantee, assume, reissue, or reinsure, or cause
4 to be guaranteed, assumed, reissued, or reinsured, one or more of
5 the insurer's policies or contracts;
6 (2) provide money, pledges, notes, guarantees, or
7 other means proper to:
8 (A) implement Subdivision (1); and
9 (B) ensure payment of the insurer's contractual
10 obligations until action is taken under Subdivision (1); or
11 (3) loan money to the insurer.
12 SECTION 17. Section 463.252(c), Insurance Code, is amended
13 to read as follows:
14 (c) A policy or contract owner, certificate holder, or
15 enrollee who claims emergency or hardship may petition for
16 substitute benefits under standards the association proposes and
17 the commissioner approves. Substitute benefits are available only
18 for a health claim, periodic annuity benefit payment, death
19 benefit, supplemental benefit, or cash withdrawal.
20 SECTION 18. Section 463.253(b), Insurance Code, is amended
21 to read as follows:
22 (b) The association shall provide money, pledges,
23 guarantees, or other means reasonably necessary to discharge the
24 insurer's duties and to:
25 (1) guarantee, assume, reissue, or reinsure, or cause
26 to be guaranteed, assumed, reissued, or reinsured, the insurer's
27 policies or contracts; or

(2) ensure payment of the insurer's contractual obligations.

SECTION 19. Sections 463.254(b), (e), (f), (g), (h), and (i), Insurance Code, are amended to read as follows:

(b) The association, in accordance with Subsections (c) and (d), as applicable, shall ensure payment of benefits identical to the benefits that would have been payable under the policy or contract of the insurer[~~, at premiums identical to the premiums that would have been applicable under that policy or contract, except for terms of conversion and renewability~~].

(e) The association shall diligently attempt to provide each known insured, enrollee, or group policy or contract holder [~~policyholder~~] with notice before the 30th day before the date the benefits are terminated.

(f) As provided by Subsections (g)-(i), the association shall make substitute coverage available on an individual basis to:

(1) each known insured or enrollee under an individual policy, or the owner if other than the insured or enrollee; and

(2) each individual who:

(A) was formerly insured or enrolled under a group policy or contract; and

(B) is not eligible for replacement group coverage.

(g) Substitute coverage is available for an individual policy under Subsection (f) only if the insured, enrollee, or owner was entitled under law or the terminated policy to continue an individual policy in force until a specified age or for a specified

1 period during which the insurer:

2 (1) was not entitled to unilaterally change a
3 provision of the policy; or

4 (2) was entitled only to change a premium by class.

5 (h) Substitute coverage is available for a group policy or
6 contract under Subsection (f) only if the formerly insured or
7 enrolled individual was entitled under law or the terminated policy
8 or contract to convert group coverage to individual coverage.

9 (i) To provide substitute coverage under Subsection (f),
10 the association may offer to reissue the terminated coverage or
11 issue an alternative policy. The association shall offer the
12 reissued or alternative policy without requiring evidence of
13 insurability, at actuarially justified rates. The reissued or
14 alternative policy may not provide for a waiting period or
15 exclusion that would not have applied under the terminated
16 policy. The association may reinsure a reissued or alternative
17 policy.

18 SECTION 20. Section 463.256(b), Insurance Code, is amended
19 to read as follows:

20 (b) The association shall set the premium according to a
21 table of rates the association adopts. The premium:

22 (1) must reflect:

23 (A) the amount of insurance provided; and

24 (B) each insured's or enrollee's age and class of
25 risk; and

26 (2) may not reflect any change in an insured's or
27 enrollee's health occurring after the original policy was most

1 recently underwritten.

2 SECTION 21. Section 463.258, Insurance Code, is amended to
3 read as follows:

4 Sec. 463.258. PREMIUM FOR REISSUANCE OF TERMINATED
5 COVERAGE. If the association reissues terminated coverage at a
6 premium different from the terminated policy's premium, the premium
7 must:

8 (1) reflect the amount of insurance provided and the
9 insured's or enrollee's age and class of risk; and

10 (2) be approved by the commissioner or a court.

11 SECTION 22. Section 463.260(b), Insurance Code, is amended
12 to read as follows:

13 (b) The association's obligations with respect to coverage
14 under a policy of an impaired or insolvent insurer or under a
15 reissued or alternative policy terminate on the date the coverage
16 or policy is replaced by another similar policy by the
17 policyholder, the contract owner, the insured, the enrollee, or the
18 association.

19 SECTION 23. Sections 463.261(a) and (c), Insurance Code,
20 are amended to read as follows:

21 (a) A person receiving a benefit under this chapter,
22 including a payment of or on account of a contractual obligation,
23 continuation of coverage, or provision of substitute or alternative
24 coverage, is considered to have assigned to the association the
25 rights under, and any cause of action relating to, the covered
26 policy to the extent of the benefit received. The association may
27 require a payee, policy or contract owner, beneficiary, insured,

1 enrollee, or annuitant to assign the person's rights and cause of
2 action to the association as a condition of receiving a right or
3 benefit under this chapter.

4 (c) The association has all common law rights of subrogation
5 and any other equitable or legal remedy that would have been
6 available to the impaired or insolvent insurer or holder,
7 beneficiary, enrollee, or payee of a policy or contract with
8 respect to the policy or contract.

9 SECTION 24. Section 463.304, Insurance Code, is amended to
10 read as follows:

11 Sec. 463.304. DISTRIBUTION OF OWNERSHIP RIGHTS OF IMPAIRED
12 OR INSOLVENT INSURER. In making an equitable distribution of the
13 ownership rights of an impaired or insolvent insurer before the
14 termination of a receivership, the court:

15 (1) shall consider the welfare of the policyholders,
16 contract owners, certificate holders, and enrollees of the
17 continuing or successor insurer; and

18 (2) may consider the contributions of the respective
19 parties, including the association, the shareholders, [and]
20 policyholders, contract owners, certificate holders, and enrollees
21 of the impaired or insolvent insurer, and any other party with a
22 bona fide interest.

23 SECTION 25. Section 463.351(a), Insurance Code, is amended
24 to read as follows:

25 (a) The commissioner shall:

26 (1) notify the insurance officials of all the other
27 states, territories of the United States, and the District of

Columbia by mail not later than the 30th day after the date the commissioner:

(A) revokes or suspends a member insurer's certificate of authority; or

(B) issues a formal order requiring a member insurer to:

(i) restrict the insurer's premium writing;

(ii) withdraw from this state;

(iii) reinsure all or part of the insurer's business;

(iv) obtain additional contributions to surplus; or

(v) increase capital, surplus, or another account for the security of policyholders, contract owners, or creditors;

(2) report to the board when the commissioner:

(A) takes an action described by Subdivision (1) or receives from another insurance official a report indicating that a similar action has been taken in another state; or

(B) has reasonable cause to believe from a completed or continuing examination that a member insurer may be impaired or insolvent; and

(3) provide to the board the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of insurers not included in those ratios.

SECTION 26. The changes in law made by this Act apply only to an insurer that first becomes impaired or insolvent on or after

1 the effective date of this Act.

2 SECTION 27. This Act takes effect September 1, 2019.