By: _____ ___.B. No. _____

A BILL TO BE ENTITLED

AN ACT

relating to the purpose, definitions, member insurers, coverage, board of directors, telephonic and videoconference meetings, powers, and assessments of the Texas Life and Health Insurance Guaranty Association.

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

SECTION 1. Chapter 463, Section 463.002 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. Chapter 463, Section 463.003 is amended to read as follows:

Sec. 463.003. GENERAL DEFINITIONS. In this chapter:

(1) "Association" means the Texas Life and Health Insurance

Guaranty Association.

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

(2) "Board" means the board of directors of the association.

(3) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or part of a policy or contract or certificate, for which coverage is provided under Subchapter E.

(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. "Covered policy" and "covered contract" may be used interchangeably in this chapter, as may "policy" and "contract".

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

(A) Accident only insurance:

(B) Credit insurance;

(C) Dental only insurance;

(D) Vision only insurance;

(E) Medicare Supplement insurance;

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

(G) Disability income insurance;

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

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

(6) "Impaired insurer" means 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 under an order of supervision, liquidation, rehabilitation, or conservation;

(B) placed under an order of liquidation or rehabilitation under Chapter 443; or

(C) placed under an order of supervision or conservation by the commissioner under Chapter 441.

(7) ~~(6)~~ "Insolvent insurer" means a member insurer that has been placed under an order of liquidation with a finding of insolvency by a court in this state or another state.

(8) ~~(7)~~ "Member insurer" means an insurer that is required to participate in the association under Section 463.052.

(9) ~~(7-a)~~ "Owner" means the owner of a policy or contract and "policyholder," "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 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.

(10) ~~(8)~~ "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(11) ~~(8-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.

(12) ~~(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:

(i) provide welfare benefits to designated welfare recipients; or

(ii) implement Title 2, Human Resources Code, or the Social Security Act (42 U.S.C. Section 301 et seq.); or

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

(13) ~~(10)~~ "Resident" means a 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 and to whom the member insurer owes a contractual obligation. For the purposes of this subdivision:

(A) a person is considered to be a resident of only one state;

(B) a person other than an individual is considered to be a resident of the state in which the person's principal place of business is located; and

(C) a United States citizen who 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 chapter is considered a resident of the state of domicile of the insurer that issued the policy or contract.

(14) ~~(10-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.

(15) ~~(11)~~ "Supplemental contract" means a written agreement for the distribution of policy or contract proceeds.

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

SECTION 3. Chapter 463, Section 463.052 is amended to read as follows:

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;~~

(1)~~(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 4. Chapter 463, Section 463.053 is amended to read as follows:

Sec. 463.053. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine or eleven individuals appointed by the commissioner as provided by this section. The commissioner has the sole discretion to determine from time to time whether the board of directors has nine or eleven individuals.

(b) If there are nine directors,

(1) t~~T~~he commissioner shall appoint three board members from officers or employees of the 50 member insurers having the largest total direct premium income according to the most recent financial statement on file on the date of appointment~~.~~;

~~(c)~~ (2) ~~T~~to give fair representation to member insurers, the commissioner shall appoint two board members from member insurers other than insurers described by Subsection (b)(1), considering the varying categories of premium income and geographical location~~.~~;

(3) the commissioner shall ensure that among the directors appointed under subsections (b) (1) and (2) life, health, annuity, and health maintenance organizations are represented; and

~~(d)~~ (4) ~~T~~the commissioner shall appoint four board members who are public representatives.

(c) If there are eleven directors,

(1) the commissioner shall appoint not less than three and not more than four board members from officers or employees of the 50 member insurers having the largest total direct premium income

according to the most recent financial statement on file on the date of appointment;

(2) to give fair representation to member insurers, the commissioner shall appoint not less than two and not more than three board members from member insurers other than insurers described by Subsection (c)(1), considering the varying categories of premium income and geographical location;

(3) the commissioner shall ensure that among the directors appointed under subsections (c) (1) and (2)life, health, annuity, and health maintenance organizations are represented; and

(4) The commissioner shall appoint five board members who are public representatives.

SECTION 5. Chapter 463, Section 463.059 is amended to read as follows:

Sec. 463.059. MEETINGS BY TELEPHONE AND VIDEOCONFERENCE. (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 purposes of establishing a quorum or voting or for any other meeting purpose in accordance with this subsection and Subsections (b)-(g). This subsection applies without regard to the subject matter discussed or considered by the members of the board at the meeting.

(b) A meeting authorized by this section is subject to the notice requirements that apply to other meetings.

(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~~.

(d) Each part of a meeting authorized by this section that must be open to the public must be audible to the public at the location specified by Subsection (c).

(e) Two-way audio communication must be available during the entire meeting between all members of the board or committee attending a meeting authorized by this section, and if the two-way audio communication is disrupted so that a quorum of the board or committee is no longer participating in the meeting, the meeting may not continue until the two-way audio communication is reestablished.

(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 ~~made available to the public~~ posted on the association's website.

(g) A vote during a meeting authorized by this section must be

taken in such a manner that the vote of each member is audible and may be verified as the vote of the member.

SECTION 6. Chapter 463, Section 463.101 is amended to read as follows:

Sec. 463.101. GENERAL POWERS AND DUTIES. (a) The association may:

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

(2) sue or be sued, including taking:

(A) necessary or proper legal action to:

(i) recover an unpaid assessment under Subchapter D; or

(ii) settle a claim or potential claim against the association; or

(B) necessary legal action to avoid payment of an improper claim;

(3) borrow money to effect the purposes of this chapter;

(4) exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life, accident, or health insurance company or a group hospital service corporation, except that the association may not issue an insurance policy or annuity contract other than to perform the association's obligations under this chapter;

(5) unless prohibited by another law, file for actuarially

justified rate or premium increases in accordance with the terms and conditions of the policy or contract, for any policy or contract for which it provides coverage under this Act;

(6) ~~(5)~~ to further the association's purposes, exercise 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.

(b) If not in default, a note or other evidence of indebtedness of the association is a legal investment for a domestic insurer and may be carried as an admitted asset.

SECTION 7. Chapter 463, Section 463.102 is amended to read as follows:

Sec. 463.102. PLAN OF OPERATION; AMENDMENTS. (a) The association shall perform the association's functions under a plan of operation approved by the commissioner. The plan of operation must:

(1) establish:

(A) procedures for handling the assets of the

association;

(B) the amount and method of reimbursing board members under Section 463.056;

(C) regular places and times for board meetings, including telephone conference calls;

(D) procedures for maintaining records of all financial transactions of the association, the association's agents, and the board; and

(E) additional procedures for assessments under Subchapter D; and

(2) contain additional provisions necessary or proper for the execution of the association's powers and duties.

(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 6~~3~~0th 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 6~~3~~0th day.

(c) Each member insurer shall comply with the plan of operation.

SECTION 8. Chapter 463, Section 463.109 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.

SECTION 9. Chapter 463, Section 463.114 is amended to read as follows:

Sec. 463.114. SUMMARY DOCUMENT; DISCLAIMER. (a) The association shall prepare a summary document describing the general purposes and limitations of this chapter and amend the document as necessary to comply with this chapter. The document must clearly and conspicuously contain on the document's face a disclaimer that:

(1) states the name and address of the association and department;

(2) warns the policy or contract holder that:

(A) the association may not cover the policy; or

(B) coverage, if available, is subject to substantial limitations and exclusions and requires continuous residence in this state;

(3) states that an insurer and the insurer's agent and a health maintenance organization and its agents are prohibited by law from using the association's existence to sell, solicit, or induce the purchase of any kind of insurance;

(4) warns the policy or contract holder not to rely on association coverage in selecting an insurer; and

(5) provides other information the commissioner prescribes.

(b) The association shall submit the document to the commissioner for approval.

(c) At the expiration of the 60th day after approval of the document, a ~~an~~ member 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~~holder.~~, contract, or certificate holder, or enrollee.

(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 provided coverage by this chapter if a member insurer becomes impaired or

insolvent. Failure to receive the document does not give an insured or policy, contract, or certificate holder, or enrollee any rights greater than those provided by this chapter.

(e) An insurer or agent may not deliver a policy or contract described by Section 463.202 that is excluded from the coverage provided by this chapter by Section 463.203 unless the insurer or agent, either before or in conjunction with delivery, gives the policy, ~~or~~ contract, or certificate holder, or enrollee a separate written notice clearly and conspicuously disclosing that the policy or contract is not covered by the association.

(f) The commissioner shall specify by rule the form and content of the disclaimer required by Subsection (a) and the notice required by Subsection (e).

SECTION 10. Chapter 463, Section 463.153 is amended to read as follows:

Sec. 463.153. AMOUNT OF ASSESSMENTS. (a) The board shall determine the amount of a Class A assessment for each account under Section 463.105, considering with respect to member insurers one or more of the following as shown by annual statements for the year preceding the date of the assessment:

(1) annual premium receipts;

(2) admitted assets; or

(3) insurance in force.

(b) Class B assessments on ~~against~~ a member insurer for each

account under Section 463.105 shall be authorized and called in the proportion that the premiums received on business in this state by the 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 impaired or insolvent member insurer became impaired or insolvent bear to premiums received on business in this state for those calendar years by all assessed member insurers.

(1) Except for assessments related to long-term care insurance, t~~T~~he amount of a Class B assessment shall be allocated among the separate accounts in accordance with an allocation formula that may be based on:

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

(b) ~~(2)~~ any other standard deemed by the board in the board's sole discretion as being fair and reasonable under the circumstances.

(2) The amount of a Class B assessment for long-term care insurance written by an impaired or insolvent insurer shall be allocated according to a methodology included in the Plan of Operation and approved by the Commissioner. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health and health maintenance organization member insurers and fifty percent to be allocated to life and annuity member insurers. This exception does not apply to long-term care insurance that is provided as a rider to a life insurance policy

or annuity contract. In that case the assessment shall be allocated to the account of the base policy or contract.

(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 11. Chapter 463, Section 463.154 is 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.

SECTION 12. Chapter 463, Section 463.159 is amended to read as follows:

Sec. 463.159. FAILURE TO PAY; COLLECTION BY COMMISSIONER. On failure of a member insurer to pay an assessment when due, the commissioner may either:

(1) suspend or revoke, after notice and hearing, the insurer's certificate of authority to engage in ~~the~~ business ~~of insurance~~ in this state; or

(2) levy a forfeiture in an amount not less than $100 each month or more than five percent of the unpaid assessment each month.

SECTION 13. Chapter 463, Section 463.201 is amended to read as follows:

Sec. 463.201. 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 health insurance policies or certificates, 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 following conditions:

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

(ii) the state in which the person resides has an association similar to the association; and

(iii) the person is not eligible for coverage by an association in any other state because the insurer or the health maintenance organization was 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; or

(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, 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.

(b) This chapter 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), if any coverage is provided by the association of another state to that person.

(c) This chapter is intended to provide coverage to persons who are residents of this state, and in those limited circumstances as described in this chapter, to nonresidents. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person may not be provided coverage under this chapter. 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, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

SECTION 14. Chapter 463, Section 463.202 is amended to read as follows:

Sec. 463.202. POLICIES AND CONTRACTS COVERED. (a) Except as limited by this chapter, the coverage provided by this chapter to a person specified by Section 463.201, subject to Sections 463.201(b) and (c), applies with respect to the following policies and contracts issued by a member insurer:

(1) a direct, nongroup life, health, accident, annuity, or supplemental policy or contract, including a health maintenance organization enrollee contract or certificate;

(2) a certificate under a direct group policy or contract;

(3) a group hospital service contract; and

(4) an unallocated annuity contract.

(b) The coverage provided by this chapter also applies with respect to all other insurance coverage written by the following entities authorized to engage in business in this state:

(1) a mutual assessment company;

(2) a local mutual aid association;

(3) a statewide mutual assessment company; and

(4) a stipulated premium company.

(c) For the purposes of this section, an annuity contract or a certificate under a group annuity contract includes:

(1) a guaranteed investment contract;

(2) a deposit administration contract;

(3) an allocated or unallocated funding agreement;

(4) a structured settlement annuity;

(5) an annuity issued to or in connection with a government lottery; and

(6) an immediate or deferred annuity contract.

SECTION 15. Chapter 463, Section 463.203 is amended to read as follows:

Sec. 463.203. POLICIES AND CONTRACTS EXCLUDED. (a) In this section, "Moody's Corporate Bond Yield Average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor to that entity.

(b) This chapter does not provide coverage for:

(1) any part of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract owner;

(2) a policy or contract of reinsurance, unless an assumption certificate has been issued;

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

(A) as averaged over the period of four years before

the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for the same four-year period or for a lesser period if the policy or contract was issued less than four years before the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier; and

(B) on and after the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available; provided however,

(C) this exclusion from coverage does not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefit.

(4) a portion of a policy or contract issued to a plan or program of an employer, association, similar entity, or other person to provide life, health, or annuity benefits to the entity's employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

(A) a multiple employer welfare arrangement as defined by Section 3, 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) 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 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;

(12) a part 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 chapter, whichever date is earlier, subject to Subsection (c); or

(13) a policy or contract providing a hospital, medical, prescription drug, or other health care benefit under 42 U.S.C. Sections 1395w-21 et seq. and 1395w-101 et seq. (Medicare Parts C and D), or 42. U.S.C. Sections 1395-1396w-5(Medicaid), or 42. U.S.C. Sections 1397aa – 1397mm (Children's Health Insurance Plan "CHIP") or a regulation adopted under those federal statutes.

(c) For purposes of determining the values that have been credited and are not subject to forfeiture as described by Subsection (b)(12), if a policy's or contract's interest or changes in value are credited less frequently than annually, 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.

SECTION 16. Chapter 463, Section 463.204 is amended to read as follows:

Sec. 463.204. OBLIGATIONS EXCLUDED. A contractual obligation does not include:

(1) 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 under one or more life insurance policies on a single life;

(2) an amount in excess of:

(A) $250,000 in the present value under one or more annuity contracts issued with respect to a single life under individual annuity policies or group annuity policies; or

(B) $5 million in unallocated annuity contract benefits with respect to a single contract owner regardless of the number of those contracts;

(3) an amount in excess of the following amounts, including any net cash surrender or cash withdrawal values, under one or more accident, health, accident and health, or long-term care insurance policies on a single life:

(A) $500,000 for ~~basic hospital, medical-surgical, or major medical insurance, as those terms are defined by this code or~~

~~rules adopted by the commissioner~~ health benefit plans;

(B) $300,000 for disability income and long-term care insurance, as those terms are defined by this code or rules adopted by the commissioner, including long-term care insurance provided as a rider to a life or annuity policy; or

(C) $200,000 for coverages that are not defined as ~~basic hospital, medical-surgical, major medical,~~ health benefit plans, 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 ~~basic hospital, medical-surgical, or major medical insurance policies~~ health benefit plans,

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 persons, in which case the maximum benefits are $5 million regardless of the number of policies and contracts held by the owner;

(7) an amount in excess of $5 million 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 Subdivision (4) irrespective of the number of contracts with respect to the contract owner or plan sponsor or one contract owner provided coverage under Section 463.201(a)(3)(B), except that, if one or more unallocated annuity contracts are covered contracts under this chapter 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 million in benefits with respect to all these unallocated contracts;

(8) 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

(9) punitive, exemplary, extracontractual, or bad faith damages, regardless of whether the damages are:

(A) agreed to or assumed by an insurer or insured; or

(B) imposed by a court.

SECTION 17. Chapter 463, Section 463.251 is amended to read as follows:

Sec. 463.251. IMPAIRED DOMESTIC INSURER. (a) This section applies only to a member insurer that is an impaired domestic insurer.

(b) With the commissioner's approval, the association may:

(1) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, one or more of the insurer's policies or contracts;

(2) provide money, pledges, notes, guarantees, or other means proper to:

(A) implement Subdivision (1); and

(B) ensure payment of the insurer's contractual obligations until action is taken under Subdivision (1); or

(3) loan money to the insurer.

(c) In taking action under Subsection (b), the association may impose any condition that:

(1) does not impair the insurer's contractual obligations; and

(2) is approved by:

(A) the commissioner; and

(B) the insurer, except in a conservation or rehabilitation ordered by a court.

SECTION 18. Chapter 463, Section 463.252 is amended to read as follows:

Sec. 463.252. IMPAIRED DOMESTIC, FOREIGN, OR ALIEN INSURER NOT PAYING CLAIMS. (a) This section applies only to a member insurer that:

(1) is an impaired domestic, foreign, or alien insurer; and

(2) is not timely paying claims.

(b) Subject to Subsection (d), the association shall:

(1) with respect to the insurer, take one or more actions that the association is authorized to take under Section 463.251 with respect to an impaired domestic insurer, subject to the conditions of that section; or

(2) provide substitute benefits instead of the insurer's contractual obligations as provided by Subsection (c).

(c) A policy or contract owner, or enrollee who claims emergency or hardship may petition for substitute benefits under standards the association proposes and the commissioner approves. Substitute benefits are available only for a health claim, periodic annuity benefit payment, death benefit, supplemental benefit, or cash withdrawal.

(d) The association is required to take action under this section

only if:

(1) the laws of the insurer's state of domicile provide that, until all payments of or on account of the insurer's contractual obligations are made by all guaranty associations and all expenses of the associations and interest on those payments and expenses have been repaid to the associations or a plan of repayment by the insurer has been approved by the associations:

(A) the delinquency proceeding may not be dismissed;

(B) the insurer and the insurer's assets may not be returned to the control of the insurer's shareholders or private management; and

(C) the insurer may not solicit or accept new business or have any suspended or revoked certificate of authority restored;

(2) the insurer is a domestic insurer that has been placed under an order of rehabilitation by a court in this state; or

(3) the insurer is a foreign or alien insurer and:

(A) the insurer has been prohibited from soliciting or accepting new business in this state;

(B) the insurer's certificate of authority has been suspended or revoked in this state; and

(C) a petition for rehabilitation or liquidation has been filed in a court in the insurer's state of domicile by the insurance official of that state.

SECTION 19. Chapter 463, Section 463.253 is amended to read as follows:

Sec. 463.253. INSOLVENT INSURER. (a) This section applies only to a member insurer that is an insolvent insurer.

(b) The association shall provide money, pledges, guarantees, or other means reasonably necessary to discharge the insurer's duties and to:

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

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

SECTION 20. Chapter 463, Section 463.254 is amended to read as follows:

Sec. 463.254. LIFE OR HEALTH INSURANCE POLICIES OR CONTRACTS. (a) This section applies only when the association is taking an action under Section 463.252(b)(2) or 463.253 with respect to a life or health insurance policy or contract.

(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~~.

(c) For a group policy or contract, the association shall ensure

payment of benefits under Subsection (b) for claims incurred before the later of:

(1) 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 contract; or

(2) the 30th day after the date the association becomes obligated with respect to the policy or contract.

(d) For an individual policy, the association shall ensure payment of benefits under Subsection (b) for claims incurred before the later of:

(1) the earlier of the next renewal date under the policy, if any, or the first anniversary of the date the association becomes obligated with respect to the policy; or

(2) the 30th day after the date the association becomes obligated with respect to the policy.

(e) The association shall diligently attempt to provide each known insured, enrollee, or group policy or contract holder 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 under an individual policy, or the owner if other than the insured; and

(2) each individual who:

(A) was formerly insured 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 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 period during which the insurer or health maintenance organization:

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

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

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

(i) To provide substitute coverage under Subsection (f), the association may offer to reissue the terminated coverage or issue an alternative policy. The association shall offer the reissued or alternative policy without requiring evidence of insurability, at actuarially justified rates, approved by the commissioner. The reissued or alternative policy may not provide for a waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure a reissued or alternative policy.

SECTION 21. Chapter 463, Section 463.256 is amended to read as follows:

Sec. 463.256. ALTERNATIVE POLICY. (a) An alternative policy issued by the association must:

(1) be approved by the commissioner;

(2) provide coverage of a kind that the association determines is similar to the coverage of the policy issued by the impaired or insolvent insurer;

(3) contain at least the minimum provisions required by the statutes of this state; and

(4) provide benefits that are not unreasonable in relation to the premium charged.

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

(1) must reflect:

(A) the amount of insurance provided; and

(B) each insured's age and class of risk; and

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

(c) The association may adopt various kinds of alternative policies to issue at a later date without regard to any particular impairment or insolvency.

SECTION 22. Chapter 463, Section 463.260 is amended to read as follows:

Sec. 463.260. LIMITS ON AND TERMINATION OF ASSOCIATION OBLIGATION. (a) The association is not liable for benefits that exceed the contractual obligations for which the insurer is liable or would have been liable if not impaired or insolvent. 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.

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

(c) If a premium is not paid before the 32nd day after the date the premium is due under a guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage, the association's

obligations under the policy, contract, or coverage terminate, except with respect to a claim incurred or any net cash surrender value due as provided by this chapter.

SECTION 23. Chapter 463, Section 463.261 is amended to read as follows:

Sec. 463.261. ASSIGNMENT OF RIGHTS. (a) A person receiving a benefit under this chapter, including a payment of or on account of a contractual obligation, continuation of coverage, or provision of substitute or alternative coverage, is considered to have assigned to the association the rights under, and any cause of action relating to, the covered policy to the extent of the benefit received. The association may require a payee, policy or contract owner, beneficiary, insured, enrollee or annuitant to assign the person's rights and cause of action to the association as a condition of receiving a right or benefit under this chapter.

(b) The association's subrogation rights under Subsection (a) have the same priority against the assets of the impaired or insolvent insurer as that held by the person entitled to receive a benefit under this chapter.

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

(d) The rights of the association under Subsection (c) 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 chapter, 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).

(e) If a provision 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 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.

SECTION 24. Chapter 463, Section 463.303 is amended to read as follows:

Sec. 463.303. ASSETS ATTRIBUTABLE TO COVERED POLICIES. (a) For the purposes of this section, assets attributable to covered policies are the proportion of the assets that the reserves that should have

been established for the covered policies bear to the reserves that should have been established for all insurance policies or health benefit plans written by the impaired or insolvent insurer.

(b) To carry out the association's obligations under this chapter, the association is considered a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies, less any amount to which the association is entitled as subrogee under Section 463.261.

(c) Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter.

SECTION 25. Chapter 463, Section 463.304 is amended to read as follows:

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

(1) shall consider the welfare of the policyholders of the continuing or successor insurer; and

(2) may consider the contributions of the respective parties, including the association, the shareholders, ~~and~~ policyholders, contract owners, certificate holders, and enrollees of the impaired or insolvent insurer, and any other party with a bona fide

interest.

SECTION 26. Chapter 463, Section 463.352 is amended to read as follows:

Sec. 463.352. ADVICE FROM BOARD. The commissioner may seek the board's advice and recommendations on a matter affecting the commissioner's duties regarding the financial condition of:

(1) a member insurer; or

(2) an insurer or health maintenance organization applying for a certificate of authority to engage in ~~the~~ business ~~of insurance~~ in this state.

SECTION 27. Chapter 463, Section 463.355 is amended to read as follows:

Sec. 463.355. FAILURE TO COMPLY WITH PLAN OF OPERATION. On failure of a member insurer to comply with the plan of operation, the commissioner may suspend or revoke, after notice and hearing, the insurer's certificate of authority to engage in ~~the~~ business ~~of insurance~~ in this state.

SECTION 28. Chapter 463, Section 463.401 is amended to read as follows:

Sec. 463.401. APPEAL TO COMMISSIONER. (a) Not later than the 60th day after the date of a final action of the association or the board, a member insurer may appeal the action to the commissioner.

(b) A member insurer appealing an assessment shall pay the assessment to the association. The association may use the money to meet the association's obligations while the appeal is pending. If the appeal on the assessment is upheld, the association shall return to the insurer the amount paid in error or in excess of the amount the commissioner determines the insurer was obligated to pay. If a member insurer does not report or inaccurately reports premium data as required for assessment purposes, then the Commissioner may assess a penalty against that member to be paid to the association.

SECTION 29. Chapter 463, Section 463.451 is amended to read as follows:

Sec. 463.451. PROHIBITED USE OF PROTECTION PROVIDED BY CHAPTER. (a) A person may not make, publish, disseminate, circulate, or place before the public, or directly or indirectly cause to be made, published, disseminated, circulated, or placed before the public, a written or oral advertisement, announcement, or statement that uses the existence of the association to sell, solicit, or induce the purchase of a kind of insurance with respect to which this chapter provides coverage.

(b) This section applies to an advertisement, announcement, or statement made, published, disseminated, circulated, or placed before the public:

(1) in a newspaper, magazine, or other publication;

(2) in a notice, circular, pamphlet, letter, or poster;

(3) over a radio or television station; or

(4) in any other manner.

(c) Except as provided by Section 463.114, the use by a person of the protection provided by this chapter in the sale of insurance is unfair competition and an unfair practice under Chapter 541.

(d) This section does not apply to the association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

SECTION 30. The changes in law made by this Act apply only to an insurer that first becomes impaired or insolvent on or after the effective date of this Act.

SECTION 31. This Act takes effect September 1, 2019.